Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 21, 2007 **Physician** 3:45 A M RAY HARRIETT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE **GEORGES** CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 6 Sev 7. Age (In vrs. last birthdav) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F May 5, 1927 St. Paul, N.C. 80 Director 240-60-0670 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location show 10b. County r 28a-f show notified at 1 ☑Yes 2 ☐ No Washington D.C. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or event, the Medical Examiner must be 20019 United States 5321 Dix Street N.E. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 → Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No **Black** Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrative Assistant</u> Government Pages 1 and 2 should be filed w nent of Health and Mental Hygie nt: If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maggie Jane McKoy Joseph Ray ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other tra 20735 9008 Fox Park Rd. Clinton, Md. Denise Ray /Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☑Removal from State 4 □ Donation 5 □ Other (Specify) Nov.28,2007 Oak Ridge Cemetery 22. Name and Address of Facility
Alexander S. Pope P.A.
5538 Marlboro Pike/Forestville, Md. 21. Signature of Funeral Service Li 20747 23a. I art I. Erner the dis \* se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only ine cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 No director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other; 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours after death e Funeral Director: filled in by the within 24 hor To the Fune completely fi

State Registrar

Medical

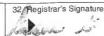
29a, Certifier

29b. Signature and title of certifier

T. TANNER MO William 31. Date filed (Month, Day, Year)

NOV 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



11701 Livingson Road Fort WASHington many sand

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

335206

29d. Date signed (Month, Day, Year)

November 21, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTATE of Translation Poppartment 73 Health and Mental Hygiene

amend items 10e-stiller of gentle 11-27-07 vt. Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 22 1508 PM **Physician** wann 2007 urnell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Min. Month, Day Year 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 2 □ F Mary 14-88-8814 3 Director 70 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le marked other then "neturet", or items 23s or 28a-f show other traumatic event, the Medical Examinar must be routhed at Balt imore Muryland 1 Nes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2404 Chelsea Terrace 21216 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Black Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Carpenter 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry /Laborer Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) To Be Swann Milton J Cales (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 McEldery 3603 tother Batter MO 2/205 Health tem 27 If item? 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State imetery, crematory or other place) Burial 2 Cremation 3 Removal from State Nov 28, 2007 Department of Importent: If eny injury or once. Jestem 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee dun 2.1 redhilton Both R4 2/229 -70 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. -Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical as a consequence of): e to (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) by Physician/Medical Examiner Hospitel or Attending Phyeicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Inknown director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 27 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 27 No Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending death. 1 🗌 Yes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 Nov- 26 - 2007 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Paul St. Suk 310 3 Malte: 110 21202 3. Registrar's Signature Month, Day, Year) 31. Date filed (Month, State

Registrar

Baltimore, Maryland 21215-0036

Box 68760,
P.O.
Records,
r Vital
Division o

certificate be executed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 22 40 pm Arthur Lee Stratton 2007 20 November 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) FRANKLIN Square Hospital Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Wonths Days Hours Min. Aug. 22, 1929 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11XM 2□ F 78 241 34 1626 North Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No Middle River Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6917 Birdwood Avenue 21220 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Processing Meat Packer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William M. Stratton Anne E. White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6917 Birdwood Avenue Baltimore, Maryland 21220 Mae I. Stratton (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory Inc. 11/26/2007 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Sicenses Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a Pah1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) in Farction myocardial 30 min Due to (or as a consequence of): astrointestinal hour Sequentially list conditions, it any, leading to immediate cause. Enter Underlying

**Physician** /Medical **Examiner** 

Department of Health a Important: If item 27 is any injury or other trau

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

sa or 28a-f show t be notified at

Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itelury or other traumatic event, the Medical Examiner

Director

þ

Completed

Be

the Maryland

with

attending physician and for use as the kind of After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

Physician/Medical þ Completed Be ( Certification: To

Medical

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dr William Andrew

NOV 2 6

William andrew Renie, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Renie

32 Registrar's Signature

Cause (Disease or injury that initiated events resulting in death) Last	c	uence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3 ☐ Ectopic			23d. Date of delivery  Month Day Year
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
25. Was case referred to medical			26. Place of De	eath Check onl one	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	€R/Outpatient 3 I	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying PI (Check only one) 2 Medical Exa	nysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s)

29c. License number

023704

9000 FRANKLIN Square DR. BALTIMORE

29d. Date signed (Month, Day, Year)

MO 21237

November 20,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Sullivan 2044 **Physician** No rember 19 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 山上 phin5 Itospital More John 10 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F MD Director 18 213-26-9237 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show must be notified at 1 XYes 2 No Director Baltimore NA MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 2 any lijury or other traumatic event, the Medical Examiner must be no once. 21215 U.S.A. 3203 Dorithan Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. Yes 2 No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black ģ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Homemaker 12th grade 3yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Savilla Cole 2 Samuel J. Cooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md Tully C. Sullivan-Husband 3203 Dorithan Road, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/16/07 Baltimore, New Cathedral 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DOMA disease or condition resulting in death) /Medical Die to (or is a consequence of) Examiner eumonia Sequentially list conditions, if any leading to immunicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed cancer Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 📈 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 212 No this certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RET-UVO MEDIENL DUCTOR NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOHNS HOPKINS HUSPITAL, GOUNGETH WOLFE STEET, BALTIMULE, MPDIGGT

State Registrar ERUCE SARATA

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

DHIMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of Ma	arylan		artment d rtificate				eg. No.	2007	37	505
В	Physicia		Decedent's Name (First, Middle			`mai T	. 1			2. Date of Dea Month	Day	Year	3. Time of	
	/Medic		4a. Facility Name (If not institution			mit		wn, or Loca	ation of Death	Nov.	18 4c. C	County of Death		/ /
	9	ш	University of Mar 5. Social Security Number			enter  [ast birthday]	Bal If Under 1	time Year Lift	Jnder 24 Hrs.	8. Date of Birth		N/A	<u>,                                      </u>	or Foreign
ы	Funeral Director		216-32-2971	1177 M 2□ E	72	Yrs.			ours Min.	Jan. 23	, Year)	35 Mary	place (State ontry) y land	or r oronger
	land ow it		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside C	ity Limits
	e Mary la-f sho tified a	Director	Maryland Anne A	rundel	Lint	hicum			<u></u>					2⊠No
	with th	I Dire	10e. Street and Number 327 School Lane				10f. Zip Co			1	0g. Citize	en of What Cou	intry?	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show deal Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marr  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ed 157 Yes 2 1 If Yes, Give Year or Dates:	No			nt of Hispar Cuban, M	nic Origin? (Spelexican, Puerto	ecify Yes or No- Rican, etc.)	1-	4. Race - Amer Black, White Specify: Wh	etc.	
Maryland 21215-0036	.⊆ - 0	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	's Education		16a. Dece (Give life.		Occupation done during retired)	g most of work	ing		d of Business/l	,	
d 2	0 0 6	Be Co	10 17. Father's Name ( <i>First, Middle,</i>	Last)		Carp	enter	18.	Mother's Name	e (First, Middle,			J11	
ylar	ould be Menta narked natic ev	To B	Roy	Smith	n	405 44-75			Carrie	al Carda Musika	- 0:1	Rov		
Mar	ages 1 and 2 should be file ent of Health and Mental Hy nt: If Item 27 Is marked oth y or other traumatic event		19a. Informant's Name/Relations  Norma B. Smith							al Route Numbe			p Coae)	
ore,	ges 1 a t of Hea If Item or othe		20a. Method of Disposition  1 Burial 2 Cremation			Place of Dispo cemetery, cre	osition (Name matory or othe	of er place)		Date	20c. Loc	cation - City or 1		1
Baltimore,	E & 5		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service	pecify)	Lou				Facility LO	udon Pai		imore, l ineral l		nd
Ba	permit. Depart Import any Inj once.	4. 9	1							Baltimo		MD 212		
	Physician /Medical	X- 1	23a. Part I. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)		10	sopho	ageal			or respiratory ar	rest,		Approxima Interval Be Onset and	te tween Death MHS
	Examiner		Sequentially list conditions	b. Sel	Sis								3 Da	ys
<b>3,09289</b>	e be executed sician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as										
P.O. Box 68	The law requires that the death certificate be exected has been signed by the attending physician ariage 2 should be detached for use as the buriat-	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	aldeath 3	⊒Ectopic preg ⊒ Other (spec				2	3d. Date of deli Month	very Day	Year
	quires that the signed by all the detaction	by	Part II. Other significant condition	ons contributing to death b	out not res	sulting in the u	ınderlying cau	se given in	Part I.	23e. Did to		se contribute to		death? Unknown
I Reco		Completed								24a. Was a autop perfor		24b. Were au prior to d death? 1 □ Yes	topsy findings ompletion of	available cause of
Vita	sIclan: Th certificate irector, pag	Be	25. Was case referred to medica examiner? 1 ★ Yes 2 No	Hospital: 157 Innati	ont 2	1 EB/Outpatio	nt 3□ DOA	Other		th <i>(Check only o</i> ome 5 ☐ Resid		COther (Spec	16.4	
n or	ding Phys After this funeral di	n: To	27. Manner of Death 1. Matural 5 □ Pendin	28a. Date of Inju	ury	28b. Time of		c. Injury at Work?	+ L Ivursing H	28d. Describe h			шу)	
Division or Vital Records,	or Attenditter death Director: in by the	Medical Certification:	2 Accident investion 3 Suicide 6 Could determ	jation	jury - At h tc. <i>(Sp</i> eci	ome, farm, st	M reet, factory, o		2 🗆 No	28f. Location (S City or Ton	treet and n, State)	d Number or Ru )	ral Route Nu	mber,
	e Hospital 24 hours e E Funeral letely filled	dical C		g Physician: To the best Examiner: On the basis of and manner si	of examina									(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifie					License nu				e signed (Monti	n, Day, Year)	
	()		Cathy	who completed source of	doath /lto:	m 23a) /Turn		5862	8479	43	Nov	18"	, 20	0/
	$\sqrt{\chi}$		30. Name and address of person Catherine Sm					altim	ione, M	1D 21	201			
	Sta	_	31. Date filed (Month, Day, Year)	1+4, 22 S. 2007 32. Regist	rar's Sign	ature	Mes!							

DHMH 17 Rev 1/2001

		_ State of Maryland /					ental Hyg	_		183
		1 - State Registrar		tificate of				Reg. No.2	07	37506
Physici	an	Decedent's Name (First, Middle, Last)     EVELYN PAGE STUBBI	NS				2. Date of Dea Month Novembe		Year	3. Time of Death 9:30 P M
/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location	n of Death	Novemb		ty of Death	9.50 F
EXAITIII	ICI	Stella Maris Hospice			onium					e County
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 图 F 7. Age (In yrs. last E 220-18-6059 81	Yrs.	If Under 1 Year Months Days		er 24 Hrs. Min.	8. Date of Birti (Month, Day Jan . 25	v, Year)	9. Birthp Coun Mary	lace (State or Foreign try) 1and
yland now at		10a. State 10b. County 10c. City, To					10d. Inside City Limits			
ne Mar 8a-f sh otified	ector	Maryland Harford	ве	lair				10- Chinan o	f Mhat Cour	1 ☐ Yes 2 M No
th with ti	al Dire	100. Street and Number 1002 Markham Court Unit A		10f. Zip Code 21	1014			10g. Citizen o		uyr
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cu ☐ Yes 2【 No			ecify Yes or No- Rican, etc.)	14. R Bl	ace - Americ lack, White, cify: Whi	etc.
thin 72 houre. e. an "natural Medical Ex	Completed t		(Give k life. D	ent's Usual Occu kind of work done OO NOT use retir	e during ma red)	ost of worki	ng	16b. Kind of		·
led wil lygien her th nt, the	Con	12 0		Secretai	~	her's Name	(First. Middle.			ucation
ld be fi ental H ked ot ic ever	To Be	Richard Morgan Morrissett					Adeliad		,	
2 shou and M is mar	-	19a. Informant's Name/Relationship (Type. Print)	,	g Address (Stree						•
1 and Health em 27 ther tr				rays Cresition (Name of natory or other pl			Pasaden Date	a, Mar		
Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	tery, cřem Have	natorý or other pl n Mem. I	Park	11-2	7-07		•	Maryland
permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygiene. Important: If item 27 is marked other than any lojury or other traumatic event, the Monce.		21. Signature of Euneral Service Licensee	Mc 32	Name and Add Cully-Po O4 Mount	ress of Fac olynia	ak Fu	neral H Pasade	ome P.A	A. rvland	21122
91.4		23a. P. rt1. Enter the disease, or complications that caused the death. Docok, or heart failure. List only one cause on each line.	o not ente	er the mode of dy	ing, such	as cardiac	or respiratory a	rest,		Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. CONGESTIVE HF. Due to (or as a consequence)	ART I							Oriset and Death
80°	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ce of):							
te be executed ysician and le burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c Due to (or as a consequenc	ce of):							
ate be ex hysician the burial	cai	d								
The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 9 ☐ Unknown		]Ectopic pregnan ] Other <i>(specify)</i>	ncy				Date of delive	ery Day Year
quires that a signed by ald be deta	by	Part II. Other significant conditions contributing to death but not resulting	g in the un	nderlying cause g	jiven in Par	rt I.		obacco use co Yes 2 ☐ No		he cause of death?
The law requires the has been signed page 2 should be	Completed						24a. Was autop perfo 1□ Yes	osy ormed?	b. Were auto prior to co death?	psy findings available inpletion of cause of
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital: 4   Impatigate 2   Impatigate 2			Ale a a		(Check only o			
ing Phys After this uneral di	ation: To	To les Zanto	b. Time of Injury	28c. Inj	4 🗆		me 5 ☐ Resi 28d. Describe I			) HOSPICE
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: K completely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, building, etc. (Specify)					City or To	vn, State)		al Route Number,
he Hosp in 24 hou he Funei pletely fill	edical	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowled and manner: On the basis of examination and manner stated.								
To t withi To tl	Me	29b. Signature and title of certifier			nse numbe	721-		29d. Date sig	ned (Month,	
12		30. Name and address of person who completed cause of death (Item 23a					.m. 05	,		(
	ate	DR. TARIQ MAHMOOD 2300 DULANEY  31. Date filed (Month, Day, Year)  32. Registrar's Signature	VAL	LEY RD.	TIMO	JNLUM	MD 210	<u> </u>		
Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 6 2007	12.23	alas						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Items 19a,29c,d per fh, dering 873, 41/26/107dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **STRAUSS** NOV CYRILE 2, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE LEVINDAL N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday, Days Hours 1 □ M 2 🔽 F 81 214-22-4743 05/10/1926 MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 2434 W. BELVEDERE AVENUE 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. WHITE 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEALER ART 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) COHEN SADIE FLEISHMAN M. LEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 14650 TRIADELPHIA ROAD - GLENELG, MD 21737 19a. Informant's Name/Relationship (Type. Print) SHELLY HARRIS / DAUGHTER
Shelley Harris 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State BNAT TSRAEL CONGPlace) 1 X Burial 2 □ Cremation 3 □ Removal from State 11/15/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Ser 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORDNARY ARTERY DISEASE Due to (or as a consequence of): Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner Examiner

use as the burial-transit

Physician/Medical

<u>Ş</u>

Completed

Be

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Certification:

Medical

attending physician

signed by the atte

page

filled in by the Director:

law requires that the death certificate be executed

or Attending Physician:

To the Hospital within 24 hours a To the Funeral C

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Completed by Funeral

Be ည

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

'natural", the Medical

Il Hygiene.

Pages 1 and 2 should be fill ment of Health and Mental H: ant: If Item 27 is marked out

permit. Pages 1 Department of h Important: If Ite any Injury or ot

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any hading to improduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

> 1 Tes 2 No 3 Probably 4 Unknown

DEMENTIA

24a. Was an autopsy performed? Yes 2 No 1□ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

HYPERTENSION

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27, Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

1 Natural

3 ☐ Suicide

2 ☐ Accident

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

Dura H WODETHWOT

D63327

November 13,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WOLDEHWOT 2434 W. BELVEDERE AVE, BALTIMORE, MD

State Registrar

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Reg. No. U U 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** P. SINGER MARGARET 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST ELIZABETHS NURSING HOME BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN28 19 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Days Hours 90 21509 8271 MARYLAND **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No BALTIMORE Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 3320 21227 ENSON AVE. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OWN HOMEMAKER HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FEDOSIA NICOLAS PUNKO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If Item 27 Is any injury or other treu 2008. CATHERINE E. BROWN 1618 HEATHER HOT. SYKOUILLE, MO 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27/2007 ELKRINGE, MO MEADOWRINGE M.P. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN Win Brun EI+ & mon Co. 6028 SYKOVILLE ROOM ELDERSBURGIND 21784 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each 179 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) men **Physician** year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25 No 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; Division 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the fi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day Year) 32. Registrar

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TW Marden Chrie lane belf no 21227

ORIGINAL

			_ For	ype or Print in E State of Marylan	d / Dep	artment of	Health and I		•	2750
20			State Registrar  1. Decedent's Name (First, Middle, Last)		Ce	ertificate of	Death	2. Date of Death	. No. 2 U U /	3 7 5 0 9 3. Time of Death
-	Physici /Medi Examir	al	Aa. Facility Name (If not institution, give	ru/s		4b. City, Town,	or Location of Death	Month	4c. County of Dea	7 - 40 p M
	Funeral Director		5. Social Security Number 6. Sep 134-14-3045	7. Age (In yrs. 83	last birthday Yrs.	If Under 1 Yea Months Day:		8. Date of Birth 06/05/19	75/ Z	thplace (State or Foreign ountry) MD
	Maryland -f show fied at	tor	Usual Residence of Decedent           10a. State         10b. County           MD         BALTIMO		y, Town or L	ocation	*			10d. Inside City Limits 1 □Yes 2 No
	ith with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 2 CANDLEMAKER CO	URT, APT. 300			208		. Citizen of What Co U.S.A	•
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show disal Examiner must be notified at	by	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	.S. 13	. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 N	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
1215-0036	C ". 40	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1-4or 5+)	(Giv life.	edent's Usual Occ re kind of work don DO NOT use retii	upation e during most of wor red)	king	b. Kind of Business	·
Maryland 2121	should be filed within and Mental Hygiene. Is marked other than 'aumatic event, the Me	To Be Co	12   17. Father's Name ( <i>First, Middle, Last</i> ) PETER		HOPE	LAPIN	18. Mother's Nan	ne (First, Middle, Ma		
, Mary	and 2 shousalth and No 27 is mailer traumal		19a. Informant's Name/Relationship (Ty HILARIE BOLTANSKY		19b. Mai 3610	iling Address <i>(Stre</i> O ANTON F	et and Number or Ru ARMS ROAD	ral Route Number, C - BALTIM	ORE, MD 2	Zip Code) 1208
Baltimore,	nit. Pages 1 and and antiment of Health ortant: If item 27 Injury or other tr		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	20b. F Nemoval from State	Place of Disp EB <sup>ete</sup> SHA	position (Name of TAME OF PARK	RTAL 11/2	1/2007   R	c. Location - City or EISTERSTO	WN, MD
Balt	permit. Pag Department Important: i any injury o		21. Signature of Fungral Service Licens	ee	;	22. Name and Add 8900 RE	•	SOL LEVIN N ROAD -		S., INC. E, MD 21208
No.	Physician /Medical Examiner		23a. Part1 En er the disease, or complete show, or here failure. List only of immediate Cause (Final disease or condition resulting in death)	ications that caused the deat ne cause on each line.				aio espiratory arrest		Approximate Interval Between Onset and Death
	xecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq						
68760,	uria uria		resulting in death) Last	Due to (or as a conseq	uence of):					
.O. Box 6	he death certificate b the attending physic shed for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1   Yes 2   No 9   Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3	I⊑Ectopic pregnal			23d. Date of de Month	elivery Day Year
Δ.	requires that the death een signed by the atter rould be detached for u	þ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the	underlying cause	given in Part I.			o the cause of death?
Records,	elaw hasb je 2 st	Completed						24a. Was an autopsy performe 1  Yes 2 L	24b. Were a prior to death?	
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Josnital:				ath (Check only one)		
ō	Phys r this ral dii	ပ္	27. Manner of Death 1 XNatural 5 □ Pending	1 Impatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpati 28b. Time Injury	of 28c. In	jury at ork?	lome 5 Residen		ecify)
Division	I or Attending after death. Director: Afte I in by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, s fy)		□ Yes 2 □ No e	28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,

To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to

Certification: To

Medical

29a. Certifier (Check only one)

30. Name and address of person

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day Year) NOV 2 6

DHMH 17 Rev 1/2001

17

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37510 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day tnastasia Tsangaris Physician Month 01:11 AM ovember 25 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BALTIMORE HOSPITAL 8. Date of Birth (Month, Day, Year) 7 - 1 7-1948 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🔽 F Hours Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 res 2 No Director Breece theNS 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or Funeral [ 62 AMARYIIIdos GRECCE NIA permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other trainer. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: Will te 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tomema OWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be H thanasio ဂ SangaRIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AHARYIII dos St. Vasaliki Isangaris - Siste 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12-1-07 Athens, Greece 22. Name and Address of Facility Pradley - Ashton Funeral Home, PA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 134 WILLOWSDring Rd. theco 11 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sep515 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner odomin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed g physician and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical guipt 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? the funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 M Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence this 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print ennis

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 26

2007

32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death **Physician** Raymond Face
4a Facility Name (If not institution, give street and number) 6.00 A.M 20 NOV 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MULTI MEDICAL NURSING HOME TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 8. Date of Birth (Month, Day, Year) June 25 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 VIRGINIA Funeral Days 10XM 2□ F Months Hours Yrs. Director 78 220-24-3171 1929 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Meryland nent of Health and Mentel Hygiene. Int: If Hem 27 is marked other than "natural", or items 23s or 28s-f show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28e-f shov invest be notified at 1 ☐ Yes 2 XXIII Directo MARYLAND BALTIMORE ESSEX 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code 1029 BAYNER ROAD U.S.A. Funeral 21221 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ty⊠Never Married 2 Married Maryland 21215-0020 1 Yes 2 XNo Specify: δ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 51/53 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSE WORK 12th grade PRIVATE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ RAYMOND HAYES NANNIE TAYLOR RILEY 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Hicks-Leeper/Cousin 1029 BAYNER RD., BALTIMORE, MARYLAND 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite eny injury or ot XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VETERANS 11/30/07 OWINGS MILLS, MARYLAND 21. Signature of Fusion Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. ollen 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) monetro Examiner Due to (or as a consequence of) Physician/Medical Examiner HYPERTENSION nouth To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 2 10 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other ဥ 1 ☐ Yes 2 ☐ No Nursing Home 5 Residence 6 Other (Specify) this I Director: After this ad in by the funerel of 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of Injury 28c. Injury at Work? edicai Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation .1 Naturel death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours of To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUPTE MD D0053150 NOU ZI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Santago 9650 Reed, Suite 110 Columbia MD 21045 CURT A SHAKUN MACA 32. Registrer's Signature 31. Dete filed (Month, Dey, Year) NOV 2 6 State Registrar

Registrar

State

31. Date filed (Month, Day, Year)

NOV26

2007

DONE !

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZIAZ MIY ZUMD, 6701 N. Charler St

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** .50 AM ames Nevember 20 2007 1 homas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Enns Hapkins Bayview Medical Center 5. Social Security Number 6. Sex - 7. Age (In vrs. last birthed Atimor Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Hours 220-18-664 926 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show e fical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director dal 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Armed Forces: 1 HYes 2 No If Yes, Give Year or Dates: WW I 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Mr. Ical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ker STE 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be မှ al an homas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md. 21222 Thomas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) -ruwnsulle 21. Signature of Funeral Service Licensee 1905 ulloh 1701 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or and a consequence of): disease or condition resulting in death) /Medical Examiner Status epilepticus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its day as the cause of the caus Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last as the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Tectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Mapner of Dea 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation Natural Accident 1 Yes 2 No | Director: / 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours at To the Funeral C Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) 30. Name and ddress of person who com +1 31. Date filed (Month, Day, 32. Registrar's Signature Year) State NOV 2 6 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

### 07-08981 Xa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

vier Tilghman	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No.													
	B	- For State tegistrar	-14)	Cen	incate of	Deam			12.1	R Date of Dea	eg. No th	21	3 Time of Death	51
Physicia edical Examir		1. Decedent's Name (First, Midd	e,Last)						- 1 1	Month Novembe	Day	Ye <b>≸⊷</b> (	3 Time of Death	
edical Examin		Xavier Tilghman  4a. Facility Name (if not institution	on, give street and nu	ımber)	4	b. City, Tow	n, or Lo	cation of E				ounty of De	eath	
•		Johns Hopkins Hospi				Baltimor	e							
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1	$\rightarrow$	If Under 2		B. Date of Bi	rth(MM/DD	/YYYY) <sup>g</sup> .	Birthplace (State or Fo	oreign
Director	- 1	220-13-2106	1 X M 2 F		21 Yrs.	Months	Days	Hours	Min.	Jan. 3	1, 1986	6	MD	
	t	Usual Residence of Decedent											10d. Inside City Li	imits
v any	10a. State 10b. County 10c. City, Town or Location												1 X Yes 2	
Maryland 28a-f show d at once.	5	MD Baltimore  100 Street and Number									10g. Citizen of What Country?			
Maryl 28a-	Director	Toe. Suleet and reuniber									, og. 0 <u>-</u>			
th the l		908 N. Benta1ou Street  11 Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe									0- 14	I. Race - A	IISA_ merican Indian, Black,	
th wit	Funeral	11. Marital Status 1 x Never Married 2 Never Married 2	12. Was De	orces?	S. If Ye	es, specify C	Suban, N	Mexican, P	Puerto Rio	can, etc.)		White, et		
er dez		21	1 Yes vorced If Yes, Give Ye	2 X No	1	Yes 2 X	No	specify:				pecify:	Anerican	
urs aft tural	ğ		Widowed 4 Divorced in Test States  15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of									d of Busine	ess/industry	
72 hor	ee	Elementary/Secondary (0-12	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)									Sandtown		
5-0036 led within 72 tygiene. other than the 14 dical	ompleted	22010 0001									tureca	re	-	
1215-0036 de filed within 72 hours a fental Hygiene. narked other than "natura vent, the Medical Examin	9	17. Father's Name (First, Middle					18	s.Motners	Name (F		a Burge			
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Be	Euş 19a. Informant's Name/Relation	gene E. Tilg	hman, Sr.	19b. Mailing	Address	(Street	and Numb	er or Rur		_		State, Zip Code)	
MD 2 d 2 shoul Ith and M n 27 is m	٩	Geraldine Burgess	/ Aunt										21216	
e, N and 2 lealth item 2 traur		20a. Method of Disposition			Place of Dispos crematory or ot		of ceme	etery,	- !	Date	20c. Lo	cation - Ci	ty or Town, State	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		1 X Burial 2 Crematic			ng Memoria				11/28	3/2007	Randa	allsto	wn, Maryland	- 1
Itin nit. Pa artmei ortan		4 Donation 5 Other 9	Specify: e Licensee		22.1	Name and A	dress	of Facility	W	ylie Fu	neral	Home.	P.A.	
Ba Per Ba		-1. 1.	( \			638 N.	Gil	nor St	reet:	Baltin	more. N	iarvlar	nd 21217	10000
Physician		23a. Part I. Enter the disease, of failure. List only one cause	or como cations that e on e • h line.	caused the death	n. Do not enter t	he mode of	dying, s	uch as ca	rdiac or r	espiratory a	arrest, shoc	k, or neaπ		
'Madical aminer		Immediate Cause (Final diseas	e a. Strangula									_	Death	-
ammo		or condition resulting in death)	Due to (or as	a consequence o	of):									
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	of):									
	Examine	cause. Enter Underlying Caus	C.	= 10	-f).									- 73
l ed	Exa	events resulting in death) Las	Due to (or as	a consequence of	Ji).									
be executed ician and urial - transit	dical	UNPENDED	AMENDE	)										
50, te be o	Medi	IF FEMALE:	23c. If ye	s, outcome of preg	gnancy		_				23d	. Date of de		
Box 68760, e death certificate be the attending physic cd for use as the bur	an/N	23b. Was decedent pregnant in past 12 months?	the 1 Live	e birth	2 F	etal death	3	Ectopic	pregnan	ісу		Month	Day Yea	ar
OX 6 eath ce attend for use	sici		Internation 1	gnant at time of d	eath 5 0	ther (Speci	fy) _							1
D. B. ithe de by the	Physician/Me	Part II. Other significant cond			resulting in the	underlying o	ause g	iven in Pa	rt I.	23e. Di	d tobacco u	use contrib	ute to the cause of dea	ith?
ires that the signed by										1 🗌	Yes 2	No 3	Probably 4 Unk	nown
ords, w require as been signed by	Completed by									24a. W	as an itopsy	24b. We	ere autopsy findings av ior to completion of cau	/ailable
COF law r has b	葿									pe	erformed?	de	eath?  Yes 2	
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<b>/ital</b> sician is cert lirecto	Be	examiner?		Inpatient 2	ER/Outpatier	nt 3 DC	DA	Other <sub>4</sub>	Nursing	g Home 5	Reside	nce 6	Other:	
n of V ding Phy After th funeral of	on: To													
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Phystician: The law requires that the death certificate be within 24 bours after death.  To the Funeral Director. After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the bu	Certification:	2 Accident In 3 Suicide 6 C	vestigation 28e. P	lace of Injury - At		eet, factory,	office b	ouilding, et			m State)		r or Rural Route Numb	er, City
Spital	Cer	4 V Homicide	1	fy) Jail/Pena		1.10	de	-4						
Di To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 Certifying one) 2 Medical E	Physician: To the examiner: On the base	sis of examination	and/or investig	ation, in my	opinion	ate and pla n, death oc	ace, and ccurred at	t the time, d	ate and pla	ace, and du	le to the cause(s)	
<b>—</b> F.2 F.8	₹	29b. Signature and title of cer		12		29c		e number				_	d (Month, Day, Year)	
			Wl. 7				O.C.	IVI.⊑.			INOV	zember z	22, 2007 	
1)	1	30. Name and address of er	son who completed	ause of death (Ite	em 23a)	enn Stree	t Rai	timore	MD 21	201				
ν\			eputy Chief Me	dical Examin . Registrar's Signa		eiiii Suee	الەت <sub>با</sub> ر	umore,	. 410 21					
1	SET?	31. Date filed (Month, Day, Ye	ar/ 32	. registral 5 Jigite	4	6								

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DVamber 17, ZOV7 1224U4 M John Thomas Voelker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ens Burni Baltimore Washington Med Ctr | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O5/18/1932 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 MM 2□ F Director 218-28-7420 75 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hyglene. The marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location a or 28a-f show t be notified at 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7644 Browns Road 21122 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Cold Storage Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph G. Voelker Margaret Mary Wilkens 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If Item 27 Is any injury or other trau Julie A. Hutt / Daughter 7901 Central Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/21/07 Glen Haven Mem Pk Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a consequence off Physician/Medical Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown o 9 Unknown نے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? rds, Medical Certification: To Be Completed by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown page 2 should Recol 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes Division or Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Magner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certif 29d, Date signed (Month, Dav. Year) 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

yn Sophia V		Pri State Of IVIA 1- For State Registrar 1. Decedent's Name (First, Middle,Last) <b>Cait</b>		tificate of		mental Hy		g. No. 2 (	0 7 3 7 5			
Physicia dical Exami		CATTLYN S.	Lyn Sopina VI	INCENT	1_		Month November					
		4a. Facility Name (if not institution, give street a Johns Hopkins Bayview Medical		41	City, Town, or Lo Baltimore	ocation of Death		4c. County of	Death			
Funeral Director		5. Social Security Number 213-43-5959 6. Sex	7. Age (In yrs. Ia	st birthday)  3 Yrs.	If Under 1 Year  Months Days	If Under 24Hrs. Hours Min.		-1994	9. Birthplace (State or Foreign Country)  MARYLAND			
w any		Usual Residence of Decedent		Town or Locatio	n DUNDA	T.K			10d. Inside City Limits 1 Yes 2 X No			
Maryland r 28a-f sho ed at once.	Director	10e. Street and Number			10f. Zip Code 2122		10	g. Citizen of Wha				
5-0036 led within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	Funeral Di	1 Never Married 2 Married Arm	s Decedent Ever in U.S ed Forces?		Decedent of Hispa s, specify Cuban, I	anic Origin? (Sp			- American Indian, Black,			
P 5 E	þ	3 Widowed 4 Divorced If Yee, or Dates:  15. Decedent's Education (Specify only highes		16a. Decedent	Yes 2 X No s Usual Occupatio	n (Give kind of v	vork done	Specify:	WHITE siness/Industry			
11215-0036 d be filed within 72 hours after fental Hygiewi. sarked other than "natural", event, the Medical Examiner.	Completed	Elementary/Secondary (0-12) Colle	ege (1-4 or 5+)		st of working life. D	OO NOT use reti	red)	EDUC	ATION			
21 be final lirked rked ent,	Be	17. Father's Name (First, Middle, Last)  JOHN FRANKLIN		CENT		LILLIA	N MA		(DASKO)			
MD 2 d 2 shoul lth and N n 27 is n aumatic	To	19a. Informant's Name/Relationship (Type, Prin JOHN F. VINCENT/E	ATHER	7115	HOLABIR	D AVE		LK, MD	n, State, Zip Code) 21222 City or Town, State			
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		1 X Burial 2 Cremation 3 Remo		rematory or other. STAN	erplace)	11-	24-07	BALT	IMORE, MD			
		21. Signature of Functial Service Licensee  23a. Part I. Enter the disease, or complications	had so you ditho dooth	12	11 CHES	SACO AV	E RO	SEDALE	,			
Physician /Medical caminer		failure. List only one cause on each line.  Immediate Cause (Final disease a. Myo	carditis r as a consequence of		e mode or dying, si		respiratory arre	est, shock, of fied	Between Onset and Death			
	er	Sequentially list conditions, if any, leading to immediate  Due to (conditions)	equentially list conditions, any, leading to immediate b									
ed ed .	Examine	events resulting in death) Last	r as a consequence of	f):		-						
50, te be executed ysician and burial - transit	ledical				T / #23a,2	7,perME,g	874, 12/19	9/07 TT 23d. Date of	delivery			
Box 6876  e death certificate the attending phy ed for use as the le	Physician/M	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregr Live birth Pregnant at time of dea Unknown	2 Feta	al death 3 er (Specify)	Ectopic pregna	ancy	Month	Day Year			
m ° ± g	by	Part II. Other significant conditions contribu		esulting in the ur	nderlying cause giv	ven in Part I.			bute to the cause of death?  Probably 4 Unknown			
of Vital Records, P.O. Box 6876  g Physician: The law requires that the death certificat the this certificate has been signed by the attending ph meral director, page 2 should be detached for use as the	Completed						24a. Was autop	sy p med? d	Vere autopsy findings available nor to completion of cause of eath?  Yes 2 No			
	Be Co	25. Was case referred to medical	· ·			of Death (Check		2 110 1	7.00 2 10			
Vit;	To B	examiner? 1 ✓ Yes 2 No Hospital:		ER/Outpatient	- []		-	Residence 6	Other:			
<b>~</b> ± . ₹ ₽	ertification:	2 Accident S Pending Investigation	Date of Injury (Month, Day,Year)	28b. Time of In	1 Ye	es 2 No		how injury occurre				
Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certif tely filled in by the funeral director,	Certific	4 Homicide determined (Sp	. Place of Injury - At ho	ome, farm, stree	t, factory, office bu	ilding, etc.	28f. Location (S or Town, S		er or Rural Route Number, City			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		e best of my knowledgesis of examination and e	ge, death occurr nd/or investigati	on, in my opinion,	death occurred	due to the caus at the time, date	and place, and d	ue to the cause(s)			
	2	29b. Signature and title of certifier	. 1		29c. License O.C.N			November	ed ( <i>Month, Day</i> , Ye <i>ar</i> ) 21, 2007			
9		30. Name and address or person who complete Pamela E. Southall, MD Assis	d cause of death (Item		Penn Street,		MD 21201					
	tate		Registrar's Signatu				VID & 1&U I					
Regis		31. Date filed (Month, Pay, Year)	المار سادسان	re								

DHMH 17 Rev 1/2001 OCME 2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 19 2007 11:40 P M VEYTSMAN IZYA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE PIKESVILLE RUXTON PIKESVILLE NURSING HOME If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) RUSSIA 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours 1 M 2 □ F 02/15/1914 219-92-9287 93 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b, County 10d. Inside City Limits 1 Ves 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5900 PARKS HEIGHTS AVE. APT. 512 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify. WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MIRON VEYTSMAN ANNIE UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOFYA DAVIDSON / DAUGHTER 7101 TRAVERTINE DRIVE #308 - BALTIMORE, MD. 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 11/21/2007 REISTERSTOWN, MD 21. Signature Funeral Service Licers 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1 Enter the disease, or conshock, or heart failure. List only nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest y one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2KNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 454 ursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

death certificate be executed and -trans physician a the burialas attending p P.0. signed by the a Division or Vital Records, been si has page 2 certificate Hospital or Attending Physician: this

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

nd Mental Hygiene. marked other than

permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event

Physician /Medical

Examiner

within 72 hours after death

Maryland 21215-0036

Saltimore,

Certification: To

Medical

after death.
I Director: After the in by the funeral

Natural Accident

3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title of

29a. Certifier

5 ☐ Pending investigation

6 ☐ Could not be

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

29d. Date signed (Month, Day, Year)

State

Registrar

To the Hospital o within 24 hours aft To the Funeral Di completely filled in

BOB 31. Date filed (Month, Day, Year) 2 6

Mati Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygiene	7 37518
	Physici	ian	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day You	3. Time of Death
5	/Medie Examir	cal	Shirley Ann Williams  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	November 20, 20	Pot Till M
	Exami	iei	Union Memorial Hospital	Baltimore	140. Sounty of t	Deau
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day, Year) 9.	Birthplace (State or Foreign Country)
	Director		214-44-3547 G3 Yrs. Usual Residence of Decedent	]		eorgía
	land ow		10a. State 10b. County 10c. City, Town or I	.ocation		10d. Inside City Limits
	Man	tor	Maryland Balt:	imore		1 XYes 2 ☐ No
	death with the Maryland ime 23s or 28s-f show if nitsel be rediffed at	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of Wha	t Country?
	23a	ral	5803 Glenkirk Court	21239	U.S.A.	
	Item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 \( \subseteq \text{Never Married} \) 2 \( \subseteq \text{Married} \) 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{Never Married} \)	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Pican, etc.) 14. Race - 1 Black, V	American Indian, White, etc.
980	urs af	<u>۾</u>	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Specify:	Black
21215-0036	within 72 hours after ene. then "natural", or Ite	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	16b. Kind of Busin	ess/Industry
12	within no. then	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	9	
	Hygie Hygie other	ပိ	12. Father's Name (First, Middle, Last)	Payroll Clerk	e (First, Middle, Maiden Sumame)	
Maryland	G a D	To Be	Farl Holland	Maude	Unknown	
ary	2 should and Men is marke	_	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Run	al Route Number, City or Town, Sta	te, Zip Code)
	and 2 ealth m 27 i			Glenkirk Court, Ba	altimore, Marylar	nd 21239
ore B	ges 1 if of H if Itea or oth			matoni or other place)	Date 20c. Location - City 1/2007 Baltimore	
Baltimore,	it. Pa idmen rtant: njury			dem. Park Ceme.		
Ba	permit. Pages 1 an Department of Heal Important: if Item 2 eny injury or other ODGE.		11011	22. Name and Address of FacilityThe		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause of each line.	1611 Park Hgts. Ave		Approximate
ì	Physician		Immediate Cause (Final disease or condition	Megal		Interval Between Onset and Death
F	/Medical		resulting in death)  Due to (or as a consequence of):	nucc		one mount
	Examiner	<b>.</b>	Sequentially list conditions, b. Coronary orden	bleed p dissore		10 years
η.	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	/		0
7,4	be executed sicien and burial-transit	Examiner	Cause (bisease or injury that initiated events resulting in death) Last  C. Hulling Turner Court			
760,	ate be executed hysicien and the burial-transit	dical	d			
89 >		Med	IF FEMALE:	Eggs Shall and State of Section	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Вох	deeth certific e ettending p d for use as l	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	⊒Ectopic pregnancy	23d. Date of Month	delivery Day Year
o.	at the de by the tached	Physician/Me	1 ☐ Yes 2 M No 4 ☐ Pregnant at time of death 5 [ 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		,
., J	The law requires that the te has been signed by the page 2 should be detached.	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	Inderlying cause given in Part I.	23e. Did tobacco use contribut	te to the cause of death?
ğ	w require been sig should b				1  Yes 2  No 3 □	Probably 4 Unknown
Vital Records,	e law re hes be je 2 sho	Completed			24a. Was an autopsy 24b. Were prior	autopsy findings available to completion of cause of
	<b>₩</b> 144	Co			performed? deat	h? Yes 2□ No
<b>X</b>	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	Other	Check only one	
<u>o</u>	Attending Physician: r death. ector: After this certific by the funeral director.	2	1 Inpatient 2 ER/Outpatie		me 5 Residence 6 Other (5 28d. Describe how injury occurred	Specify)
0	ath. r: After e funer	atlor	27. Many or of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Month, Day Year)	of 28c. Injury at Work?  M 1 Yes 2 No	zac z soonise new injury cooding	
DIVISION	I or Attendate after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number of City or Town, State)	r Rural Route Number,
2	vital or A					
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, deal (Check only one) 2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	and at the time date and place and	due to the cause(s)
	o the	Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth. Dav. Year)
)			Auma Fathowship, MD	AT 2438946	410 November	20 2007
	2		29b. Signature and title of certifier  Annu Fallowskia MD  30. Name and address of person who completed cause of death (Item 23a) (Type,   When Festically Month, Day, Year)  31. Date filed (Month, Day, Year)  NOV 2 6 2007	Print)	2000	/ /
	Sta	6	31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)  31. Date filed (Month, Day, Year)	"lemonal stop	Judal , MD	
	Registra	ar	NOV 2 6 2007	·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/23/2007 10:30PM Brenda Kay Willig 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Baltimore Washington Med Ctr Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 03/25/1953 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1□M 2**1**F 215-60-1610 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Jackpine Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2∎No Specify 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Everett E. Gardner Kathleen Baker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Willig / Husband Jackpine Drive, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11/26/07 Baltimore, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Heretensin Cater's Silvionia arten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of mellitus Jaheter Due to (or as a consequence of):

Physician /Medical Examiner Examine

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or Items 23a or 28a-f shov i ilcal Examiner must be notified at

1 and 2 should be filed within 72 hours after ( Health and Mental Hygiene. em 27 is marked other than "natural", or Itel

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is

Baltimore, Maryland 21215-0036

Director

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Completed

Be

requires that the death certificate be executed physician and sthe burial-tran been signed be should be deta

Division or Vital Records, P.O. Box 68760.

within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu

•	d						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions co	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3⊟Eo		pregnancy pecify)		23d. Date of do Month	elivery Day Ye <i>a</i> r
	ntributing to death but not re	sulting in the unde	erlying	cause given in Part I.	23e. Did tobac		to the cause of death? Probably 4 □Unknown
					24a. Was an autopsy performed	prior to death?	
25. Was case referred to medical examiner?				26. Place of De	eath Check onl one		
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 🖔	<b>≰</b> ER/Outpatient	3□ D	OA Other: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Sp	ecify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Spec	iome, farm, street	t, facto	ry, office	28f. Location (Stree City or Town, S	t and Number or F tate)	Rural Route Number,
29a. Certifier (Check only one)	sician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death o ation and/or inves	ccurre	d at the time, date and place on, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)
29b. Signature and title of certifier			29	c. License number	29d	Date signed (Mor	oth Day Year)

142820

29d. Date signed (Month, Day, Year)

, PASAdeNA Md. 21122

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Christophen

Mar). and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

de BoniA u.D.

NOV 2 6 2007

3708 Mauntoin Rd.

			Registrar Amend#1,perMD,g874,	, 12/5/07 TT	Cer	tificate of L	eaith and i Death		lene 200	7 37520	
	Physic	ian	Tenn	ny I. Wilder				2. Date of Deat	er 21, 20	3. Time of Death 18:56 M	
	/Medi Examii		4a. Facility Name (If not institution, give street and Carroll Hospital Ce	d number)		4b. City, Town, or	Location of Death		4c. County of Death Carroll		
e e e e e e e e e e e e e e e e e e e	Funeral Director		5. Social Security Number 215–42–1010 6. Sex	7. Age (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 29,	0.5	Birthplace (State or Foreign Country)	
	Maryland a-f show ifled at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Carrol1	10c. City, Town	n or Lo		iottsvil	le		10d. Inside City Limits 1 □ Yes 2 ☑ No	
	th with the 23a or 28 1st be not	Funeral Director	10e. Street and Number 2426 Forest Hill Road			10f. Zip Code 211	04	1	0g. Citizen of What USA	Country?	
920	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. d Forces? /es 2 🏹 No s, Give or Dates:		Vas Decedent of His f Yes, specify Cubar ☐ Yes 2☐XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ar Black, W Specify:	merican Indian, hite, etc. White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any hiury or other traumatic event, the Medical once.	Completed	15. Decedent's Education (Specify only highest grade comple  Elementary/Secondary (0-12)  Collection  Collection	ted) ge (1-4or 5+)	(Give I	ent's Usual Occupa kind of work done d OO NOT use retired) nsportati	uring most of worl	king	16b. Kind of Busines	ecurity Admn.	
Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name ( <i>First, Middle, Last</i> ) William H. Wilder				18. Mother's Nam Ada	e (First, Middle, M King	Maiden Surname)		
	and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationship (Type. Print) Mrs. Jean Wilder (Spou	ise) 2	426		ill Rd.,	Marriot	City or Town, State		
Baltimore,	Pages 1 ment of H ant: If iter		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal fit 4 □ Donation 5 □ Other (Specify)	ate 20c. Location - City or Town, State 5/2007 Lisbon, MD							
Ball	permit Depart Import any In		21. Signature of Funeral Service Licensee/	IE & CHAP 84 (410	EL, PA (B	Sox 195)					
68760,	Carbon and American and American and American and American and American as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e to (or as a consequence of to (or as a consequ	Cy of):					Approximate Interval Between Onset and Death	
Records, P.O. Box (	The law requires that the death certil the has been signed by the attending age 2 should be detached for use a	Physician/Me	in the past 12 months?	outcome pf pregnancy ve birth 2 ☐ Fetal death regnant at time of death nknown		Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year	
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing	to death but not resulting in っゃいっ	the un	derlying cause giver	n in Part I.			to the cause of death?	
_	ician: The law certificate has be ector, page 2 sh	Completed	25. Was case referred to medical						prior to death? No 1 □ Ye	autopsy findings available o completion of cause of ? es 2 □ No	
>	hysician: his certifica I director, p	o Be	examiner?	☐ Inpatient 2 ER/Out	tnatient			h (Check only one	nce 6 □Other (Sp		
Division or Vital	nding Phy th. : After this e funeral c	tion: To	27. Manner of Death 28a. D	ate of Injury 28b. T		28c. Injury Work?	4 Li Nursing Ho	28d. Describe ho		pecity)	
DIVIS	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. r	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pl	lace of injury - At home, far uilding, etc. <i>(Specity)</i>	m, stre			28f. Location (Str. City or Town,	eet and Number or i State)	Rural Route Number,	
	he Hospit n 24 hours he Funera pletely fille	edical (	29a. Certifier (Check only one)  12 Certifying Physician: To 2 Medical Examiner: On the and medical Examiner:	the best of my knowledge, ne basis of examination and nanner stated.	, death d/or inv	occurred at the time estigation, in my opi	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)	
	Tot Tot Com	M	29b. Signature and title of certifier  Herroral Saron	f . m.D.		29c. License	number 29d. Date signed (Month, Day, Year)  /// 2 2 / 4 7				
	8		30. Name and address of person who completed of Howard Socients, M	ause of death (Item 23a) (7	Type, P	rint)	Street	West	min sten	md 21157	
	Sta Registr		31. Date filed (Month, Day, Year) 3:	2. Registrar's Signature		barte			·		

Examiner physician and s the burial-transit P.O. Box 68760. attending p Records, Division or Vital the Hospital or Attending within 24 hours after deatl To the Funeral Director:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f sl Examiner must be notified

Medical

Director

Funeral

<u>ک</u>

Completed

Be

filed within 72 hours after death with the Maryland

Maryland

Baltimore,

**Physician** 

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Physician/Medlcal 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗷 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 📉 No ၉ 27. Manner of Death Certification: 1 Natural
2 Accident 3 Suicide 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year, State NOV 2 6

DHMH 17 Rev 1/2001

Registrar

			For State		State of Ma	-	partment of I <i>ertificate of</i>		and Menta		ne .№2 A A	7	27522
	*		1. Decedent's Name (First, Middle, Last)  2. Date of Death									1	3. Time of Death
6.75 10.75 1	Physicia /Medic		GREGORY	DEFRI	EECE WILK	ERSON			Nov	ember	14,200	7 7	16:58 PM
)	Examin		4a. Facility Name (If no				4b. City, Town,				4c. County of	Death	
	Funant		Ho ly Cr 5. Social Security Num			e (In yrs. last birtho	Silver ay) If Under 1 Year	If Under	24 Hrs   0 Date	of Birth	. 9	. Birthp	lace (State or Foreign
Ŀ	Funeral Director		226-94-2		1 <b>X</b> M 2□F	49 Yrs	Months   Davs	Hours	Min. Jun	e 24,	1958 N	Couin <b>EW</b>	York
	w w		Usual Residence of De 10a. State 10	ecedent 0b. County		10c. City, Town o	Location					1	0d. Inside City Limits
	Maryli -f sho fled at	tor	MD P	rince (	George	Upper M	rlboro						1 □Yes 2 No
	th the or 28a e noti	Director	10e. Street and Number	er		L	10f. Zip Code			10g	. Citizen of Wha	at Coun	ntry?
	s 23a nust b	eral [	13010 Mo	11y Ber		Francis II 6	20772		ining /Smanify Voc	or No	USA 14. Race -	Americ	an Indian
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 23a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married  3 □ Widowed 4 [		12. Was Decedent Armed Forces? 1 ☐ Yes 2√2 If Yes, Give Year or Dates:	No	<ol> <li>Was Decedent of If Yes, specify Cul</li> <li>1 ☐ Yes 2 X No</li> </ol>			tc.)	Black,	White,	
215-0036	2 hou natura ical E	ted	15	5 Decedent's F		16a. De	ecedent's Usual Occu	pation	et of working	16	b. Kind of Busir	ess/Ind	dustry
21	within 7 iene. than "r he Med	Completed	Elementary/Seconda		College (1-4or 5	i+)	ive kind of work done e. DO NOT use retire				letropol		
d 21	filed w Hygie other ti	ပို	17. Father's Name (Fit	rst, Middle, Las	4 <u>4</u>	Vic	e Presiden		operation of the company of the comp			tio	n Services
Maryland	ould be Mental arked o	To Be	Arthur	Wilke:	rson			Yvor	nne G <b>i</b> l	pin			
lary	2 should and Men is marker aumatic		19a. Informant's Name	e/Relationship	(Type. Print)		ailing Address (Stree				•		*
	1 and 2 Health em 27		Alfreda Hi 20a. Method of Dispos		kerson Spou		10 Molly		Road, U		c. Location - Cit		
Baltimore,	e			Cremation 3	Removal from State		sposition (Name of crematory or other pla ide Cremat				Richmond		
altir	permit. Pag Department Important: I any injury c		21. Signature of Fune			Souths	22. Name and Addr						
_ 	o a E E E		John!	1.	ie		115 E. Br					nd,	
			23a. Part1. Enter the shock, or heart f Immediate Cause (Fir		mplications that caused y one cause on each lin		enter the mode of dy	ing, such as	cardiac or respira	atory arrest	t,		Approximate Interval Between Onset and Death
je .	Physician /Medical		disease or condition resulting in death)		и	a consequence of):						-	
0	Examiner		Sequentially list condi	itions		y Artery	Disease						
1	ed sit	niner	Sequentially list condi- if any, leading to immediate. Enter Underlyi Cause (Disease or inju- that initiated events	ediate ing urv		a consequence of):							
12	execun n and ial-trar	Examin	that initiated events resulting in death) Las	st	c. Hyperte Due to (or as	a consequence of):							
68760,	ficate be executed physician and is the burial-transit	edical		•	ed End Sta	age Renal	Disease						
Box 6		J/Me	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, outcome						23d. Date of	of delive	ery
P.O. Bo	0 0	Physician/M	in the past 12 mg 1 Yes 2 N 9 Unknown	onths?	1∐Live birth 4∏Pregnant at 9∏Unknown	2 ☐ Fetal death time of death	3 □Ectopic pregnan 5 □ Other (specify)	СУ			Month	1	Day Year
	law requires that the de as been signed by the a 2 should be detached t	by Ph	Part II. Other significa	ant conditions	contributing to death b	ut not resulting in th	e underlying cause g	ven in Part I	1. 236				he cause of death?
ord	w require been sig should b	ted k								1 🗌 Yes	2 <b>X</b> No 3	☐ Prob	oably 4 🕅 Unknown
3ec	has by	Completed							248	a. Was an autopsy	pric	or to co	ppsy findings available mpletion of cause of
tal	ician; The certificate harector, page		25. Was case referred	d to medical	1			26 Place	1 Death (Check	performe Yes 22	No 1	]Yes	2 <b>X</b> No
or Vital Records,	Physician: r this certific ral director,	To Be	examiner? 1 ☐ Yes 2 📉 No		Hospital:	ent 2 ER/Outpa	tient 3 DOA	la a ru	ursing Home 5[		ce 6 □Other	(Specif	(y)
0 0	ding Physician; The In. After this certificate he funeral director, page		27. Manner of Death  Natural	5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. Tim	ry Wo			scribe how	injury occurred		
Division	r Attending er death. rector: After by the funer	Certification:		investigation	be 280 Place of init	ury - At home, farm	M 1	Yes 2		ation (Stre	et and Number	or Rura	al Route Number,
Ω	al or A s after al Dire	Sertif	4 ☐ Homicide	determine	building, et	c. (Specify)				or Tòwn, i			
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 (Check only 2 one)	X Certifying F ☐ Medical Exa	Physician: To the best amlner: On the basis o and manner st	f examination and/o	eath occurred at the or investigation, in my	time, date ar opinion, dea	nd place, and due ath occurred at th	to the cau e time, dat	se(s) and manr e and place, an	ner as s d due t	stated. o the cause(s)
	To the To the COMP	ž	29b. Signature and titl	le of certifier	< P-			se number			I. Date signed (		
			120	1	Zt,MD		G006	1148	_		11/16/2	.00 /	
	10		30. Name and address		o completed cause of d On			ve. Su	ite 102	, Sil	ver Spr	ing	, MD 20910
ē.	Sta		31. Date filed (Month,	Day, Year)		ar's Signature	mall 2						
100	Registr	ar	NO.	v 2 6 20	07 Christe	is the							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Department	artment of Health and Me tificate of Death	ental Hygien	
I	Physici /Medi		1. Decedent's Name (First, Middle, Last)  Herschel 1. Wartik		2. Date of Death Month Da	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)  Edenwald	4b. City, Town, or Location of Death	40	Baltimore
	Funeral Director		5. Social Security Number  6. Sex  1 M 2 F  7. Age (In yrs. last birthday)  83 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Year Apr 4, 192	9. Birthplace (State or Foreign Country) 0h10
	n Manyland 8-f ehow iffed at	tor	10a. State         10b. County         10c. City, Town or Loc           MD         Baltimore         Tows			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28	al Director	10e. Street and Number 800 Southerly Avenue #1307	10f. Zip Code 21286	1	itizen of What Country?
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "neturel", or Items 23a or 28a-f ehow matic avent, Its Madical Examiner mat be notified at	by Funeral	1 Never Married 21 Married 1 1 1 Yes 2 No	Vas Decedent of Hispanic Origin? (Speci Yes, specify Cuban, Mexican, Puerto Ri ☐ Yes 2∑ No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white
Maryland 21215-0036	thin 72 hou e. an *neture Madical E.	Completed b	15. Decedent's Education (Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of working O NOT use retired)	g 16b. F	Kind of Business/Industry
and 21	ba id id ave	Be	12 5+ art  17. Father's Name (First, Middle, Last)		(First, Middle, Maider	esign n Sumame)
Maryla	d 2 sith ar	으		Lena Mo G Address (Street and Number or Rural I Outherly Avenue #1	Route Number, City	
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tre once.		20a. Method of Disposition  1	44		ocation - City or Town, State
Balt	permit. Departr Importa any inji		Ba Ba	Name and Address of Facility ate Anatomy Board ( ltimore, MD 21201		ltimore Street
	Prrysician		23a. Part   Enter the disease or complications that caused the death. Do not ente shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	the mode of dying, such as cardiac or the mode of dying, such as cardiac or the mode of dying.	respiratory arrest,	Approximate Interval Between Onset and Death
1	/Medical Examiner	e	Due to (or as a consequence of):	Long failore	- 1 72	2 mg
og,	cartificate be executed iding physician and ise as the burial-transit	I Examiner	resulting in death) Last  Due to (or as a consequence of):  cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
Box 68/60	cartifi Iding Ise as	lan/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		-	Cod Date of delivery
	it the death by the atter tachad for u	hysic	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
cords, I	w raquires that the dibaen signad by the should be detachad	Ω	Part II. Other significant conditions contributing to death but not resulting in the unc	lerlying cause given in Part I.		use contribute to the cause of death?  No 3 Probably 4 Unknown
Sec.	The lay ate has page 2	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 \[ \text{Yes} \] 2 \[ \text{No} \]
OI VICAL	는 는 등	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient  27. Manner of Death 28a. Date of Injury 28b. Time of		Check only one)  5 ☐ Residence  d. Describe how injure	
VISION	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Diractor: After thi completely filled in by the funeral i	Certification:	1	Work? M 1 ☐ Yes 2 ☐ No	f. Location (Street an	nd Number or Rural Route Number.
5	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical Cer	29a. Certifier (Check only)  29a. Medicel Examiner: On the basis of examination and/or invegored.	occurred at the time, date and place, and	d due to the cause(s)	and manner as stated
1	To the within 2 To tha complet		and manner stated.			
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	29c. License number  D 29 7 6 9  Fint)  5 (6 N. kg/hy)	b 0 6 1	16107
	Stat Registra	ا پ	31. Date filed (Month, Day, Year)  NOV 2 6 2007	& Milling	1201	Le VI York

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08490 State of Maryland / Department of Health and Mental Hygiene Chandler V. Wynn 2007 37524 1- For State Certificate of Death Rea. No Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day November 1, 2007 1033 hrs Medical Examiner Chandler V. Wynn 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Edgewater 205 Washington Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State orunk If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 10 k 6. Sex **Funeral** oreign Min. Months Days Hours Country) Director Aug 31, 1939 68 Yrs 2 F 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County Yes 2 X No Edgewater 23a or 28a-f show notified at once. MD Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21037 205 Washington Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status unk , or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk White, etc. Armed Forces? Never Married Married Yes imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after conent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", on yr other traumatic event, the Medical Examiner m Specify: white Yes 2 X No specify: If Yes, Give Year Divorced Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 111 Penn Street Baltimore, MD 21201 O.C.M.E. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition ltimore, crematory or other place) Cremation 3 Removal from State Burial 2 Donation 5 X Other Specify: in state 22 Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Service Licensee Director Approximate Interval rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and ere. List only one cause on each line Death /Medical a. Chronic alcohol abuse Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED #23a\_PTT\_27\_perMF, e873\_\_11/27/07\_TT 23c. If yes, outcome of pregnancy ending physician use as the burial -Box 68760 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Dav Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Ö signed b ş Yes 2 No 3 Probably 4 ✔ Unknown Cocaine use Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? death? ✓ Yes 2 No 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: of Vital Be Hospital: 1 Other; examiner? Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient DOA Inpatient this 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) Manner of Death Certification: 1 X Natural Division Yes 2 No Pending Funeral Director: tely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the l and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 0

Assistant Medical Examiner

Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

November 2, 2007

2007

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedept's Name (First, Middle, Last) Dav 4b. City, Town, or Location of Death County of Dealf of not institution. give street and number) lliamspo Date of Birth (Month, Day, ec 25, Social Security Number 7. Age (In vrst last birthday Min. Davs 2∏ F Months Hours 1 40 Mississippi 1909 538-34-2992 97 Dec Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Williamsport MD Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21795 16505 Virginia Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: 32-60 Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 21 No Specify. 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) military officer U.S. Army 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Christine Anderson Charles Dudley Watts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19553 Lorraine Terrace Hagerstown, MD 21742 Augustus Watts Jr/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Sign ture of Funeral Servi Licensee S. Wade Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) un Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23d. Date of delivery 23 Year Month Day se contribute to the cause of death? Pa 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

and

Physician /Medical

Examiner

**Funeral** 

Director

28a-f show

the Medical Examiner must be notified at

'natural", or items 23a or

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygis Important: If Item 27 is marked other i any injury or other traumatic event, ti

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

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death with the Maryland

Examine burial-tran is certificate has been signed by the attending physician director, page 2 should be detached for use as the buria Physician/Medical þ Completed Be ပ Certification:

The law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Division or Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year				
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unkn				
		24a. Was an autopsy performed?  □ Yes 2 □ No 24b. Were autopsy findings ava prior to completion of cause death?  1 □ Yes 2 □ No 1 □ Yes 2 □ No				
25. Was case referred to medical	26. Place of Death (Che	eck only one)				
examiner? 1 ☐ Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home	Home 5 Residence 6 Other (Specify) A55 S				
27. Manner of Death  Displayment S □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  28d. I	Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of illury - At home, lathi, street, lactory, office	ocation (Street and Number or Rural Route Number City or Town, State)				

State Registrar

Medical

E 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a)

MO

Money

29b. Signature and title of certifier

29a Certifier

32 Registrar's Signature

354

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ADRIGNUE

Menne

FLOWERS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

22 5 G 32 Registrar's Signature

garde)

Greene

29c. License number

Street

BALTIMORE, MO

29d. Date signed (Month, Day, Year)

07-08959 Mark Yuspa Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lark Yuspa		State of Maryland /	•	rtment of tificate of		Mental I		201	7 2752	
Registrar Physician/ 1. Decedent's Name (First, Middle,Last)			Cert	ilicale of	Dealli		2. Date of De		3. Time of Death	
Medical Examiner MARK			YUSPA					er 19, 2007	1227 hrs	
7		4a. Facility Name (if not institution, give street and number)  Carroll Hospital Center		4	b. City, Town, or L Westminster		th	4c. County of Dea	ath	
Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24H	rs. 8. Date of I	Birth(MM/DD/YYYY) 9. E		
Director		220-50-2284 1X M 2 F	46	Yrs.	Months Days	Hours	04/04		Country) MD	
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	Town or Location	on				10d. Inside City Limits	
<b>≥</b>	5	MD BALTIMORE	BA	LTIMOR	E				1 Yes 2 X No	
th the Maryla 23a or 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?		
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	盲	4307 DANLOU DRIVE  11. Marital Status 12. Was Decedent	Ever in II S	12 Was	21207 Decedent of Hisp	anic Origin? (	Specify Ves or I	U.S.A.	erican Indian, Black,	
leath w	Funeral	1 Never Married 2 v Married Armed Forces?			s, specify Cuban,			White, etc.	STOUT TIGHT, DIOOK,	
) ( ( ( ( ( ) ( ) ( ) ( ) ( ) ( ) ( ) (	by F	3 Widowed 4 Divorced If Yes, Give YearAIR	FORC		Yes 2 X No			Specify:	WHITE	
2 hours "natur	ed ed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5			's Usual Occupations of working life.			16b. Kind of Busines	s/Industry	
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examine.	Completed	5+		PHYSIC	IAN			MEDI	CAL	
	Be Co	17. Father's Name (First, Middle, Last)	v	USPA	1	8.Mother's Na ROCHE	, .	e, Maiden Surname)	RLACK	
		WARREN  19a. Informant's Name/Relationship (Type, Print )			Address (Street			umber, City or Town, Sta	ite, Zip Code)	
MD and 2 sho alth and m 27 is		ROCHELLE YUSPA / MOTHER	Tool B		DANLOU D		BALTIMO Date	RE, MD 2120		
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is nigury or other traumatic.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Sta			UNG MENS	-	21/2007			
Iltim nit. Pa artmen oortant rry or o	ł	4 Donation 5 Other Specify 21 Si nature of Funeral Service Light see			ame and Address			EVINSON & B		
Perr Perr Perr Perr Perr Perr Perr Perr	-	Michael truger			8900 RE	ISTERS1	OWN ROA	D - PIKESVI	LLE, MD 2120	
Physician /Medical		23a. Part I. Enter the disease, or complication I that caused failure. List only one cause on each life	the death. I	Do not enter th	e mode of dying, s	uch as cardia	or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and Death	
taminer	1	Immediate Cause (Final disease or condition resulting in death)  a.   Ox codor  Due to (or as a conse		oxication :					Death	
		Sequentially list conditions, b.								
	ii.	if any, leading to immediate Due to (or as a consequence of):								
ted nsit	if any, leading to immediate  Cause Finiter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):									
t <b>0,</b> e be executed ysician and burial - transit	ledical	X AMENDED 18 #23	per f	th g873	11-26-0	7 <b>vt</b>				
760, icate be physici the buri	ĕ,	IF FEMALE: 23c. If yes, outcom		ancy				23d. Date of delive		
Box 6876( death certificate the attending phy ed for use as the b	sician/M	past 12 months?	time of dea	th	al death 3 L er (Specify)	Ectopic preg	nancy	Month	Day Year	
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ords, P.C. w requires that as been signed to should be deta	ete	24a. Was an 24b. Were autopsy autopsy prior to comple								
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be a proper page 3 s	Completed						pei	formed? death?	completion of cause of Yes 2 No	
tal Rectian: The	35. Was case referred to medical 26.Place of Death (Check only one)									
f Vit Physic er this e	위	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other:								
on of onding Ph.	ertification:	27. Manner of Death  28a. Date of Injury (Month, Day/Year)  1 Natural 5 Pending  28a. Date of Injury (Month, Day/Year)  1 Yes 2 X No  unk								
VISIOI or Atten or Atten fter death Director: in by the	Eg	2 Accident 3 Suicide 6 X Could not be 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Ro								
Divisior ospital or Attend hours after death ineral Director:	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
Division of Vital   To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.								ated. the cause(s)		
To To com	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date sign						29d. Date signed (M			
		(alunt			O.C.N	1.E.		November 20,	2007	
6		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
Sta		31. Date filed (Month, Day, Year) 32 Registrar	's Signatur		B 9					
Registr	ar	NOV 2 6 2007 / Decision	20	A PARA						

Division or Vital Records, P.O. Box 68760, Hospital or Attending within 7

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d, Date signed (Month. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, 32. Registrar's Signature Year) State 6 Registrar **ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Mary Catherine Burkhard 5:30 A.<sup>M</sup> \*Medical November 24, 2007 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Nursing Home Montgomery Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Aug. 25, 9. Birthplace (State or Foreign Country) West Virginia Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 235-32-6638 Director 84 Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be l Farsta Court 20850 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 2 Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health an⊄ Mental H tant: If item 27 is marked oth Be James Benjamin Hoover Catherine Mary Snively 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Elizabeth Ann Burkhard/Daughter 1 Farsta Court, Rockville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Montgomery Crematorium 27, 2007 Bethesda, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 Millen M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hypertensive Heart Disease /Medical Due to (or as e consequence of): **Examiner** Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Apur The law requires that the death certificate be executed signed by the attending physician and all be detached for use as the burial-transit Dementia Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? ate has b 24a. Was an autopsy performed? 1□ Yes 2 X No certificate 2 No tal or Atten.
urs after death.
veral Director: After this ceru...
'n by the funeral director, pr 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2No ů 1 | Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be To the Hospital or Atte within 24 hours after der To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💢 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JOSAN D0047330 November 26, 2007 momes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas V. Joseph, M.D. 50 W. Edmonston Drive, Suite 207, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Gegistrar's Signature State NOV 2 7 Registrar 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 **Physician** 21 Day 2007 11:30p M Hazel Butler Jr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 4002 Norfolk Ave Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours M 2□F Director 213-54-4059 55 01 21 NC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov must be notified at Director 1X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. 4002 Norfolk Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Truck Driver Monroe Muffler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Hazel Butler Sr. Mamie Dumas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rachel Butler-Wife 4002 Norfolk Ave, Baltimore, Md 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 11/27/07 Owings Mills, Md Funeral Service Licensee Sign 22. Name and Address of Facility 00 4300 Wabash Ave, Baltimore, Md 21215 3a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death i mediate Cause (Final dineas or condition restring in death) Physician Due to (or as a consequence of): Cancer Year /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and I-trar burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Year 5 ☐ Other (specify) signed by the at I be detached fo 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ponknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has autopsy performed? 1 Yes 2 No certificate 2 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3∏ DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of 29c. License number certifier 29d. Date signed (Month, Day, Year) 0

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DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 7 2007

instruction of the state of the

Azriel Hirschfeld 10 A Greene Steet Daltimore MD 2

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-09045 State of Maryland / Department of Health and Mental Hygiene Kevin Dwayne Beard Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Kevin Dwayne Beard November 23, 2007 0250 hrs **Medical Examiner** Kevin Dyayne c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** St. Joseph Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours Director 384-80-8495 7-12-1962 1 XM 2 F Mich Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County 1 X Yes 2 No NA 23a or 28a-f show notified at once. Md. Baltimore 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 2000 E. 30th Street 21218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 2 X Married Never Married Yes 2 X No Specify: Black f Yes, Give Year Yes 2 X No specify: Widowed Δ Divorced item 27 is marked other than "natural", traumatic event, the Medical Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 18.Mother's Name (First, Middle, Maiden Surname) 12th grade 1 yr Unemployed and Mental Hygiene. 17. Father's Name (First, Middle, Last) Ravmond Beard Elizabeth Hollimon Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Dwayne Johnson 144 Ponce De Leon Apt. 1118, Atlania, Ga. 30308 20c. Location - City or Town, State of Health 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition nportant: If it jury or other t crematory or other place) Burial 2 XCremation 3 Removal from State Pages 1 Greenmount Cem. 12-1-07 Baltimore, Md Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F.H. East 1101 E. North Ave., Baltimore, Md 21202 adus Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Death 'Medical Infective endocarditis with complications Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed and tran Physician/Medical X UNPENDED #I.Det perME.g873m 11/27/07 TT / #23a,PII.27,perME.g874, 12/17/07 TT Box 68760, e attending phys for use as the bu 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. Yes 2 No 3 Probably 4 ✔ Unknown Þ ۳. Chronic intravenous drug use pleted Records, 24b. Were autopsy findings available 24a. Was an has been prior to completion of cause of autopsy performed? death? Com 1 🗸 Yes ✓ Yes 2 2 No certificate Hospital or Attending Physician: 7 24 hours after death. 26 Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other<sub>4</sub> Hospital: examiner? Nursing Home 5 Residence 6 DOA Inpatient 2 FR/Outpatient 3 this 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Division X Natural Yes 2 Pending Director: d in by the f Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 or Town, State) determined (Specify) Funera Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 23, 2007 O.C.M.E. all 30. Name and address of person who completed cause of death (Item 23a) i pi nd 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	or maryiana / E	•	ficate of L		ia monta			, No. 201	37 3753	
Physici ledical Exami		1. Decedent's Name (First, Middle,La						te of Death		3. Time of Death 0550 hrs		
ieuicai Exami	ner	Kendrick  4a. Facility Name (if not institution, gi	Bowman ve street and number)  4b. City, Town, or Location of Dr					vember	15, 2007 4c. County of Dea			
		Sinai Hospital	373									
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign										
Director		220-29-7779   1 XM 2 F   17 Yrs.   Months   Seys   10015   Mill   8-12-1990   Country   Md.										
any		Usual Residence of Decedent  10a. State									10d. Inside City Limits	
<u> </u>	r	Md. NA Baltimore 1								1 X Yes 2 No		
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Code					10g. Citizen of What Country?		
th the 23a or notifie		1817 Wadsworthway			21239					USA		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Menla Hygienei. Intel 71 is marked other than "natural", or items 23a or 28a-fish unit. If them 27 is marked other than "natural", or items 23a or 28a-fish or other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.										
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hours natur Exami	ed k	45 Days to the Education (County and 10 Land			during most of working life, DO NOT use rel					16b. Kind of Busines	ss/Industry	
136 hin 72 e. than "	Completed				Fast Food				McDona]		's	
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than numatic event, the Medica	Con	17. Father's Name (First, Middle, Las	st)			18.Mother's Name (			e (First, Middle, Maiden Surname)			
2121 uld be fil Mental I marked	Be	Keith		wman				cilia		Kel	-	
AD 2 2 shoul h and M 27 is m imatic	ပို	19a. Informant's Name/Relationship ( Keith Bowman	Father							per, City or Town, Sta ce, Md. 2	ate, Zip Code)	
s 1 and 2 s of Health ar If item 27		20a. Method of Disposition			ace of Dispositi	on (Name of c		Date		20c. Location - City		
MOF Pages ent of nt: If		1 Burial 2 X Cremation 3 4 Donation 5 Other Specif			ematory or othe			11-28	3-07	Baltimor	e, Md.	
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signati re of Funeral Service Lice				me and Addre	ss of Facility	Mar	ch F.	.H. East		
Physician		23a. Part I. Enter the disease, or com	onlications that caused the	e death C	1]	Ol E.	North A	Ave.,	Balti	more, Mar	yland 21202 Approximate Interval	
/Medical		failure. List only one cause on e	each line.				g, 000 <b>0</b> 0 0 <b>0</b>	u.u.u.			Between Onset and Death	
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wounds (2) of Head  Due to (or as a consequence of):										
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760, ficate be ex g physician the burial												
that the death certified by the attending detached for use as	Physician/	2   Fetal death   3   Ectopic pregnancy   Month   Day   Pregnant at time of death   5   Other (Specify)									Day Year	
he he	hys	Part II. Other significant conditions	9 OHKHOWH		otalin no line Alban vivo	d	-i i- D-4	. [7	330 Did to	naces una contributo	to the cause of death?	
P.O es that t igned by	þ	Part II. Other significant conditions	contributing to death b	ut not res	uiting in the un	denying cause	e given in Part	1.			Probably 4 Unknown	
tal Records, P.C. rian: The law requires that certificate has been signed ector, page 2 should be dete	ompleted							—   <sub>12</sub>	24a. Was a		autopsy findings available	
of Vital Records, ng Physician: The law require the confidence has been signed in a confidence of the	dmo							—   <sub>1</sub>	autops perform Yes 2	med? death		
Vital Recysician: The his certificate director, page	ပ	25. Was case referred to medical				26.Pla	ce of Death (C				100 2 110	
is si fi	To B	100 2 110	Hospital: 1 Inpatient		R/Outpatient			Nursing Hom			her:	
_ = _ \ 2		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year Nov 15, 2007	r) 2	28b. Time of Inj 0231 hrs	´   _	jury at Work? Yes 2 ✓ N	lSubi	Describe h ect shot	ow injury occurred		
Division tal or Attendines after death.  al Director:	icati	2 Accident Investiga	28e Place of Injury	y - At hom	ne, farm, street,			28f. L			Rural Route Number, City	
Divis ospital or A hours after or meral Direc	Certification:	Suicide 6 Could not be determined (Specify) Outside (Specify) Outside Could not be determined (Specify) Outside (S									nore, MD	
re Hosp n 24 ho ee Fund letely f												
To the within To the comple	Medical	29b. Signature and title of certifier  29d. Date signed (Mor										
		230. Signature and the meaning			Q .C.M.E.				November 16, 2007			
1	30. Name and address of person who completed cause of death (Item 23a)											
3		Patricia Aronica-Pollak M				111 Penn 9	Street, Balt	imore, M	D 21201			
St Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Low	SE D						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOWEMBER<sup>ay</sup>23, 2007 1:32A M inkman /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Haltimore 4b. City, Town, or Location of Death Examiner Center Towson If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months 1 ☐ M 2 💆 F 214-38-9105 Director 10V 22,1938 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 28a-f show a or 28a-f show t be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No arkville altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21234 -Ivenue Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Driscoll Elementary/Secondary (0-12) College (1-4or 5+) 12 countant 7 Is marked other traumatic event, t 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Villiam ဥ Margaret Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Ro e Number, City or Town, State, Zip Code) item 27 | Brinkman K. John HVENUE Parkville 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages
Department of
Important: If it
any injury or o
once. 1 ABurial 2 □ Cremation 3 □ Removal from State Sulaney Valley memorial Gardens 11/26/2007 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Md 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Syrs-Parkville
8800 Harford Road Parkville md 21234 21. Signature of Funeral Service Licensee Stave a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCER /Medical Due to (or as a consequence of) Examiner LIVER FAILURE Sequentially list conditions, if any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a purseougnes of The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PULMONARY EMBOLI 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate Division or Vital 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1X Natural Injury death. 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46356 avem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 21204 7601 OSLER DRIVE, TOWSON. MARYLAND TABASSI M. D. KHOSROW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26, 2007 **Physician** Month MARY McHALE BOLAND November 3:50 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Heart Homes Baltimore Lutherville If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗓 F 97 Director 212-34-0855 May 16, Ireland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 St. Francis Road Funeral 21286 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) years Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael McHale P Margaret Gibbons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Boland Ousborne (daughter) 607 St. Francis Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 11-27-07 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland 21212 21. Signature of Funeral Service Licensee Alegan Fellowse 6500 York Road Baltimore,
23a. Part1. Enter the riseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due lo lor as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

or Vital Records, P.O. Box 68760, Division

28a-f show

tems 23a or iner must be n b

"natural", or Item

permit. Pages Department of Important: If It any injury or o

Baltimore, Maryland 21215-0036

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notified

To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29a, Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV27 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13a) (Type, Print) M. Charles St. Bolto. Md Zczog

29c. License number

29d. Date signed (Month, Day, Year)
November 26, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Socke 101 /Medical Facility, Name (If not institution, give, City, Town, or Location of Death **Examiner** 4c. County of Death Medica TIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours 1 M 2 □ F 084-22-1252 78 Director 1929 New York June 27, Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at 1.☐Yes 2☐No Directo Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or 4017 W. Garrison AVenue 21215 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. 1 ☐ Never Married 2☐ Married 1 Yes 2 No If Yes, Give Year or Dates: , or Baltimore, Maryland 21215-0036 1 ☐ Yes Sa No Specify. þ 3 Widowed 4 Divorced Specify: Black 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 27 is marked other than ", r traumatic even Elementary/Secondary (0-12) College (1-4or 5+) BGE 11th grade Crane Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Booker Estelle Griffin ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Department of Health Important: If item 27 any injury or other troone. 27 Reva Booker/ Wife 4017 W. Garrison Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12/4/87 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem. Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Livensee 22. Name and Address of Facil Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. mmediate Cau e (Final disease or condition resulting in death) Onset and Death Heratcoellular Carcinoma **Physician** /Medical Due to ( r as a consequence of): Examiner Sequentially list conditions Dividu (ur sala consequence o); Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): P.O. Box 68760,7 physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) ed by the a detached f 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 cate has been signade bage 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2<mark>⊎</mark> No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of Certification: 28d. Describe how injury occurred After or Attending 1 Natural (Month, Day 5 Pending investigation death. 1 ☐ Yes 2 ☐ No hours after death uneral Director: 2 Accident the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours af

To the Funeral D

completely filled i Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435T18192 Paula Rosenblatt MD 25,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paula Rosenblatt 22 South Green Street, Department of Medicine, Balt. MD 2001 Kosenblatt

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death Reg. No. 2. Date of Death 1. Decedent)s Name (First, Middle, Last) 3. Time of Death OROWICZ Month 2115 200 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore City N/AGood Samaritan Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days 1 ☑ M 2 ☐ F 218-18-5508 83 Maryland Jan. 16,1924 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 10a. State 1 ☐ Yes 2 X No Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 United States 6702 Railway Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Sheet Metal Mechanic Martin Marrietta 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Agnes Borowicz Andrew Borowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland Mrs. Irene D. Borowicz (Wife) 6702 Railway Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 142 Burial 2 ☐ Cremation 3 ☐ Removal from State Stanislaus Cem. 11/20/2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 21. Signature of Funeral Service Licensee 6 23a. Part1. Enter the disease, or complications that caused the death. Do not entur the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but no resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

/Medical Examiner The law requires that the death certificate be executed burial-trar Records, P.O. Box 68760, physician the attending pl ed by the a been page 2 or Vital Physiclan: director, After this within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral of Hospital or Attending Division

**Physician** 

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical

**Physician** 

Director

Funeral

Completed by

Be

P

Examine

Physician/Medical

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Be Completed

Certification: To

Medical

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

/Medical

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and little of certifier

29a. Certifier

and manner stated.

29c. License number D 2:5 3 91

29d. Date signed (Month, Day, Year)

em 23a) (Type, Baint) -och Kalven Blvd, Baltimore MO 21239 address of person who completed cause of death (Item 23a) (Type, Paint)

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 7 2007

To the

			Please	Type or Print in B						gible.		
			For	State of Maryland				d Mental Hy	giene <sub>2</sub>	07	37	537
		7	State Registrar	14	Cei	rtificate of	Death	2. Date of De	Reg. No.		3. Time	of Death
	Physicia		1. Decedent's Name (First, Middle, Las Pamela F. Bre					Month Novemb	Day	Year 200		0 A M
2	/Medic Examin		4a. Facility Name (If not institution, give Stella Mari:	e street and number)		4b. City, Town, o			4c. Cou	nty of Death	h	
	Funeval		5. Social Security Number 6. S		st birthday)	If Under 1 Year	If Under 24 I	Hrs. 8. Date of Bi	rth	9. Birtl	hplace (State	e or Foreign
	Funeral Director		213-68-9606 1 Usual Residence of Decedent	□M <b>¾</b> □F 55	Yrs.	Months Days	Hours N	Ain. Jan <sup>th, T</sup>	34 Year 95	3 Mai	rylan	d
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at		10a. State 10b. County Baltime	1	Town or Lo	River					10d. Inside 1 □Ye	City Limits es 2 X No
	h the l	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Co	untry?	
	th with		17 N. Hawth	orne Road		2122			USA	2	ican Indian	
	tems tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H If Yes, specify Cub	fispanic Origin an, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	E	Black, White		
036	ours afte ral", or I	by	XXNever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		1 □ Yes 2 <b>(</b> Î No	Specify:			ecify: W		
15-0	n 72 ho "natu edical	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)	(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most of d)	working	16b. Kind o	f Business/ craf		
212	d withi	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)	Traf	fic Spe						
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. tiem 27 is marked other than "natural", or Items 23a or 28a-f show tiem 27 is marked other than "natural", or Items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be C	17. Father's Name ( <i>First, Middle, Last</i> <b>J.C.</b> Bre					Name (First, Middle ene Roar		name)		
	ind 2 shoualth and M 27 is mai		19a. Informant's Name/Relationship (  Donna Wa	Type. Print) gus/ Sister	19b. Maili 5387	ng Address <i>(Street</i> 7 Sunnyf	and Number of	or Rural Route Num. Ct. Elli	cott	City	MD 2	1043
nore,	ages 1 a ent of He it: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	emetery, cre	osition (Name of ematory or other pla Cremato		Date 1/26/200			rown, State	ID
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Lice					300 Mace al Home			alto. 21	MD 221
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	pplications that caused the death	. Do not en	ter the mode of dyi	ng, such as ca	rdiac or respiratory	arrest,		Approxir Interval	nate Between nd Death
4	Physician		Immediate Cause (Final disease or condition	a BLADDER CANCE							Offset a	Id Death
1	/Medical Examiner	П	resulting in death)	Due to (or as a consequ	ence of):							
	uič	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause ruisease or minity	b. — Due to (or as a consequ	ience of):							
<sup>50,</sup> \	be executed cian and purial-transit	I Examiner	that initiated events resulting in death) Last	C. Due to (or as a consequ	ience of):							
68760,	physicate by the control of the cont	dica		d								
.O. Box (	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	□Ectopic pregnand □ Other <i>(specify)</i> _	су		23d.	. Date of de Month	livery Day	Year
<u>α</u>	uires that the de signed by the a Id be detached f		Part II. Other significant conditions	contributing to death but not resu	ulting in the	underlying cause gi	ven in Part I.	23e. Dio	tobacco use	contribute t	o the cause	of death?
rds	quires n sign ald be	d by						_   15	]Yes 2□N	lo 3∏P	robably 4	₩Unknown
Records,	law requir as been si 2 should	Completed						24a. Wa	opsy	prior to	utopsy findir completion	ngs available of cause of
E R		Con						1□ Yes		death? 1 ☐ Yes	s 2 No	
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital: 4 - Innerticut 2 -	EB/Outnotic	2 DOA Ot	hor	f Death <i>(Check onl)</i> ing Home 5 ☐ Re		Other (Sa	noify) HO	PDTCE
o	Phy rthis rald	. To	1 ☐ Yes 2 📉 No  27. Manner of Death	1 Inpatient 2 28a. Date of Injury	28b. Time				e how injury o	-	ecily) HU	SPICE
ion	Attending r death. ector: After by the fune	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		yes 2 □ No					
Division	or Attendafter death Director:	Certification:	3 Suicide 6 Could not l 4 Homicide determined		ome, farm, s	treet, factory, office		28f. Location City or 7	(Street and Nown, State)	umber or F	lural Route i	Vumber,
_	Hospita Hours Funeral tely filled	Medical Ce	29a. Certifier  (Check only 2 Medical Example)	hysician: To the best of my kno amber: On the basis of examina and manner stated.	wledge, dea tion and/or	ath occurred at the investigation, in my	time, date and opinion, death	place, and due to the control occurred at the time	ne cause(s) an	d manner a ace, and du	as stated. ue to the cau	se(s)
	To the within 2	Me	29b. Signatule and title of certifier			29c. Licer	se number		29d. Date s	igned (Mon	nth, Day, Yea	ar)
			1	1			143	725	111	126/	07	
	H		30. Name and address of person who				TIMONI	UM, MD 21	093			

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier For State Registrar Amend #8, perFH, C873, 11/27/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 50 20 20007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2122 If Under 1 Year If Under 2 th Point LD If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9/1/1917 9. Birthplace (State or Foreign Country) **Funeral** 248-38-053 Days 1 M 2 DF Director 20017 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 48s 2 No Directo BALTO COUNTY 10f. Zip Code 10g. Citizen of What Country? ō NORTH POINTRD Items 23a 21224 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Itam 27 Is marked other than "natural", or Items 23 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 140 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: BLACK Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chock 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BARBON ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Itam 27 is any injury or other tra 5027 BLOW DOD Ininton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20722 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation S □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BAITO, MD HReline 57. 234 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause opeach line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician emensy /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine resulting in death) Last attending physician a for use as the burial-I Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 22 No 24a Wasan certificate has tirector, page 2 s 1 Yes RINO 25. Was case referred to medical examiner? 26. Place of \_\_ath | Check on | one Hospital: 1 ☐ Inpatient 1 🗌 Yes No No Other: ■ Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury

to the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, death.

the Maryland

Baltimore, Maryland 21215-0036

Medical Certification: To Be

After thi naral Director: A within 24 hours after To the Funaral Direct

State Registrar

29b. Signature and title of certifier

6 Could not be

2 Accident 3 Suicide

4 Homicide

29a. Certifier

pd cause of death (Item 23a) (Type, Print)

1 Tes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year)

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For 1_ State	State of M		epartment of			7000	07520
			Registrar  1. Decedent's Name (First, Middle, La	st)		Certificate of	Death	2. Date of De	Reg. No. /	3 7 5 3 9
	Physic /Medi		JESSIE	J. BEI	NNETT			NOVEMBE	R 14 2007	6:00 P <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, giv SAINT THOMAS MOI	,			or Location of De $\Gamma TSVILLE$		4c. County of Deat	
-	Funeral Director		Social Security Number 6. S		ge (In yrs. last birth		If Under 24 H	Irs. 8 Date of Birt	h 9. Birt	thplace (State or Foreign ountry)
	<u>D</u>		Usual Residence of Decedent		70			PECEMBE	K 21 1950	GEORGIA
	show	'n	10a. State 10b. County		10c. City, Town					10d. Inside City Limits  1 Yes 2 □ No
	the N 28a-f notifie	rect	MD PRINCE 0	EORGE	HYATTSVI	LLE 10f. Zip Code			10g. Citizen of What Co	
	th with	al D	5617 HAMILTON MAN	OR DRIVE,	#2	20782	2		U.S.A.	
36	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cut  1 ☐ Yes 2 No		(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: <b>BI</b>	e, etc.
2-0036	r2 hou natura ical E		15. Decedent's Ed	ducation	16a. D	ecedent's Usual Occu	pation		16b. Kind of Business/	'Industry
7	d within 72 ho giene. r than "natu the Medical	Completed	(Specify only highest gra	College (1-4or t	o+)	Give kind of work done ife. DO NOT use retire		vorking		
12.0	it,	S	7TH  17. Father's Name (First, Middle, Last	)	PRO	FESSIONAL		lame (First, Middle,	PRIVATE  Maiden Surname)	<u> </u>
<u>lan</u>	e d ita	To Be	FELTON BENNETT					B. BLACKM	-	
Maryland	s 1 and 2 should F Health and Men tem 27 is marke other traumatic.		19a. Informant's Name/Relationship (	Type. Print)	19b. i	Mailing Address (Stree	t and Number or	Rural Route Numbe	er, City or Town, State, 2	Zip Code)
	1 and Health em 27 ther tr		DRUSCILLA BENNET  20a. Method of Disposition	T/WIFE		7 HAMILTON Disposition (Name of	MANOR I	DR # 2 HY	ATTSVILLE, M	
D D	Pages nent of int: If Its		1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cemetery,	crematory or other pla			ASHINGTON,	,
baltimore,	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Licer			22. Name and Addre	ess of Facility	J. B. JEN	KINS FUNER	AL HOME
н			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that caused	the death. Do no				ER, MARYLANI	Approximate Interval Between
Ì.	Physician /Medical Examiner	Œ la	Immediate Cause (Final disease or condition resulting in death)	a. ATHE		SIS CARDIO		***		Onset and Death
Ã	icate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of)					
%,0070	cate be physicia the bur	dical		d			<u>.</u>			
O. BOX o	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after deem, to the Teurate deem, To the Funeral Director After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	y		23d. Date of del Month	ivery Day Year
COIDS, P	quires that in signed by uld be deta	by	Part II. Other significant conditions o	ontributing to death b	ut not resulting in th	ne underlying cause giv	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
חבבים	The law re ate has bee page 2 sho	Completed						24a. Was a autop perfor	an 24b. Were au sy prior to o rmed? death? 2⊠No 1 □ Yes	utopsy findings available completion of cause of
אונס	iclan: Sertific ector,	Be	25. Was case referred to medical examiner?	114-1				eath (Check only o		
5	Phys r this ral dir	- To	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatie	ry 28b. Tin	Ment 3 DOA			lence 6 Other (Speciow Injury occurred	cify)
5	nding h. r Afte fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		ry Wo	rk?  Yes 2∐No	Zou. Describe II	ow injury occurred	
2	s after decal Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injubulding, etc	ury - At home, farm c. <i>(Specify)</i>	, street, factory, office		28f. Location (S City or Tow	treet and Number or Run, State)	ural Route Number,
	the Hospit in 24 hour the Funer ipletely fills	Medical (	29a. Certifier 1   (Check only one)  1   Certifying Ph 2   Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination and/	leath occurred at the to or investigation, in my	me, date and pla opinion, death oc	ace, and due to the occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	vith von	2	29b. Signature and title of certifier	MD		29c. Licens	olo O		29d. Date signed (Monti	
	Q	-	30. Name and address of person who	. "	eath (Item 23a) (Ty		0100		11-16-6	<i>t</i>
	0		TAHMINA AHMED M	.D. 831 UN	IVERSITY	BLVD EAST	# 27 SI	LVER SPR	ING, MARYLA	ND 20903
	Sta Registra	e ar	TAHMINA AHMED M 31. Date filed (Month, Day, Year) NOV 2 7	2007 32. Hegistra	ar's Signature	Spertie				

DHMH 17 Rev 1/2001

		Physici ু/Medio Examin	2
ži,		uneral irector	
	Maryland	-f show fied at	

			1 - For State Registrar		Cert	ificate of	Death	Re	eg. No. 00	3/540
	Dhyoisid		1. Decedent's Name (First, Middle, La		1	<u> </u>		2. Date of Deat Month	th Day Yea	3. Time of Death
1	Physicia ∞/Medic		G CAUYS	BEN		)		vovem b		1
	Examin	er	4a. Facility Name (If not institution, gir	e street and number)	nter	4b. City, Town, o	T T. M. ()	NE	4c. County of D	TENUME
	Funeral				yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9.1	Birthplace (State or Foreign Country)
L.	Director		213 3, 2.11	1 □ M 250xF	72 Yrs.	World's Days	Hours Will.	8. Date of Birth (Month, Day, July 28,	1935	VA
	and w		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Loca	ation				10d. Inside City Limits
	Maryl Fied a	to	MD			Balti	more			1 X Yes 2 □ No
	th the or 28a e noti	Director	10e. Street and Number		,	10f. Zip Code			0g. Citizen of What	1.15
	ath wi	ral	1725 Sbbottston S	<del></del>	- 110 140 141	December 4	21218		14 Baco - A	USA merican Indian,
(0	be filed within 72 hours after death with the Maryland ital Hygiene. et other than "natural", or tems 23a or 28a-f show event, the Medical Examiner must be notified at event,	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 EX No If Yes, Give			lispanic Origin? (Spe an, Mexican, Puerto F	Rican, etc.)	African	hite, etc. American
036	ral", o	ρ	<b>3</b> Widowed 4 □ Divorced	If Yes, Give Year or Dates:	11	□Yes 2. No	Specify:		Specify:	
21215-0036	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give ki	nt's Usual Occup ind of work done O NOT use retired	during most of working	g	16b. Kind of Busine	ss/Industry unk
12	filed within Hygiene. other than "	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	me. De	nurs	•			
pq 5	at Hygi other vent, tl	Be C	17. Father's Name (First, Middle, Las	t)			18. Mother's Name		*	_
/lar	should be filed and Mental Hygi is marked other aumatic event, <u>t</u> f	70 E	Raymond I	Merring				Joseph:	ine Highsmit	:h
Maryland	nd 2 and 2 and 2 the and 27 is		19a. Informant's Name/Relationship Gladys Bennett / Dau		_		and Number or Rura er Street; Ba			e, Zip Code) 2 <b>1217</b>
Baltimore,	00		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 [	Removal from State	**	atory or other plac	ce)		20c. Location - City	
tim	permit. Pag Department Important: I any Injury c		4 □ Donation 5 □ Other (Spec	fy)	Mount Zion	Cemetery Name and Addre	11/30/		Baltimore, N Funeral Hom	
Bal	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lice	nisee C			or Street; 1			
8			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nelications that caused the	death. Do not enter	the mode of dyir	ng, such as cardiac o	r respiratory arr	rest,	Approximate Interval Between
187	Physician		Immediate Cause (Final disease or condition	ACUT!	E TNIT	MARIN	CANTAL	Ken	unoyha	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a col	nsequence of):				J	1
ı.	- Administra	-	Sequentially list conditions,	bbue to (or as a co	nsequence of):					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,					
o,	ficate be executed physician and is the burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):					
68760,	ate be	Medical		d						
	certification ding places to se as t		IF FEMALE:	23c. If yes, outcome pf pr	regnancy				22d Date of	dolivon
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burfat-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2☐ 4☐Pregnant at time	Fetal death 3 □	Ectopic pregnancy Other <i>(specify)</i> _	У		23d. Date of Month	Day Year
P.O.	t the c by the	hys	9 Unknown	9□ Unknown						
	ires that the de signed by the a I be detached		Part II. Other significant conditions	contributing to death but no	t resulting in the und	derlying cause giv	en in Part I.	23e. Did tol		e to the cause of death?
Örc	w require been si	eted	Par Phi			(1)	2 4 5 . 5		_ /	
or Vital Records,	he law has t ge 2 s	Completed by	JET SPNEV	X Vai	CVICI	1115	Ease	24a. Was a autops perfor	sy prior med? deat	e autopsy findings available to completion of cause of h?
tal			25. Was case referred to medical				26. Place of Death			Yes 2□No
ΓV	Physici this cer al direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA Oth	ner: 4 Nursing Hor	ne 5 ☐ Reside	ence 6 Other (5	Specify)
0 0	ng I		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	28c. Inju		28d. Describe ho	ow injury occurred	
Division	death. ctor: / y the fi	icati	2 Accident investigation 3 Suicide 6 Could not	oe 280 Place of injuny	At home farm stree		Yes 2 □No	tst. Location (S	treet and Number o	r Rural Route Number,
Οį<	after i Direction by	Certification:	4 Homicide determined	building, etc. (S	pecify)	-,,		City or Tow	n, State)	,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu			hysician: To the best of my miner: On the basis of exa						
	thin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (M	
	T W L		200. Signature and title of certifier	,	nna	DE				
-1	7		30 Name and address of person who	completed cause of death	(Item 23a) (Type, P	rint)	200	2	or CIWICE	er 23, 200
-			UdIKT BON	ACUM MO	3015	TPAU	UPU!	BultI	MUNO	mo and
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	COL				
	Registr	ar	NUV & 1 20	07 Doner	Is for	after 1				

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Records, P.O. Box 68760. CROGHAN or Vital Division

NOVEMBER

State

Registrar DHMH 17 Rev 1/2001

one) 29b. Signature

nd title of certifier

NOV 2 7

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

2300 DULANEY VALLEY RD.

32. Registrar's Signature

ense number

TIMONIUM, MD 21093

29d. Date signed (Month. Dav. Year) 11/26/07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 37543 State of Maryland / Department of Health and Mental Hygien 2 17 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 21 2007 **Physician** 12:15 P NOV avrence Colegrove /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BELAIR HEALTH AND REHABILITATION CENTER BELAIR HARFORD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**X** M 2□ F 200-28-939 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a State 10b County or 28a-f show the Madical Examiner must be notified at Harford Count 1 ☐ Yes 2 No Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number #118 21014 States boowtA United Kd 238 Funeral 14. Race - American Indian tema 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed by Year or Dates: "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Il Hygiene. Leonard Stallman Carpenter NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: if Item 27 is marked oth eny linjury or other treumatic event ODEs. Be E. Sanner Haro Id Colegrove Massie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colegrare (wife) 5. Atword Rd. # 118 555 Bel AI MD Irene 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evans Rupral Chapel War. 23, 2007 Forest Marijant 22. Name and Address of Facility | & Cronntin Services - Bel Air Evans Knorn (Chapel & Cronntin Services - Bel Air 21. Signature of Funeral Service Licensee Forest Hill 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failured List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No 24a. Was an autopsy performed certificate 1 ☐ Yes 2.□No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeref Director: After this certific completely filled in by the funeral director. 26. Place Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo Certification: To 2 ER/Outpatient 3□ DQA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 on who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 1/2001 Manuel La 31. Date filed (Month, Day, Year)

NOV 2

7 2007

OLF GROVE

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:02 PM 11 21 2007 Marie Agnes Currier /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Lutherville 4 Weston Court If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🙀 F 89 217-09-8786 10/13/1918 Balt., Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show a or 28a-f show Lutherville Baltimore Maryland 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States of America within 72 hours after death with 21093 4 Weston Court permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b by Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2☐No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2√No White Specify: 3₺ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) oe filed wn. Net Hygiene. Ne**r than "r** Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Michael Griffin Agnes Marie Kremer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor C. Boyer/ daughter 4 Weston Court Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Cathedral
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) 26, 2007 Baltimore, Maryland 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A 21. Signature of Funeral Service Licensee Timonium, Maryland 21093 2325 York road Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Themers DISEAL Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mod 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown CI 1 TYes 245. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1□ Yes 2☑ No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient မ 27. Manner Death 1 Unatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 □ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D 15 \$ 7 / MD | 29d. Date signed (Month, 11/26/07) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AW MENCE BOAS MD 54 SCAT ADAM RD CEKERSVILLE MED 21030

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 3 7 5 4 5

			1 - State Of IVIa		rtificate of I		_	eg. No.	31343
Н		8	Decedent's Name (First, Middle, Last)				2. Date of Death	h Day Year	3. Time of Death
Н	Physicia /Medic		Jane C. Cerny				Nov. 17,	2007	8:10 P <sup>M</sup>
	Examin	er <sup>6</sup>	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Deat	
	- A		Gilchrist  5. Social Security Number   6. Sex 7. Age	e (In yrs. last birthday)	Tows If Under 1 Year	OII If Under 24 Hrs.	8. Date of Birth	Baltir 9. Birt	
Ш	Funeral Director	1	215-50-6197 <sup>1□M 2</sup> ¥F	85 Yrs.	Months Days	Hours Min.	May 30,	Year) Co	hplace (State or Foreign untry)
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Many a-f sh fled	ţò	MD Baltimore	Parky	ville				1 ∐Yes 2 X No
	th the or 28; e not	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath wi	ral	8800 Walther Blvd.		212			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ★Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 ▼ If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🎛 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
12-0	"natura	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occup	ation during most of worki	ing	16b. Kind of Business/	Industry
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b	a filed al Hyg other /ent, i	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N	faiden Surname)	
<u>lar</u>	uld be Menta arked	70 E	Alexander Cathcart			Magdel	ine Felb	inger	
lan	2 sho and l		19a. Informant's Name/Relationship (Type. Print)					City or Town, State, 2	Zip Code)
<u>ح</u> ش	f and Health In 27 Ther to		Donald F. Cerny/ Son  20a. Method of Disposition	20h Place of Disno	nsition (Name of	Baltimore		234 20c. Location - City or	Town State
Baltimore, Maryland 21215-0036	Pages I ment of H tant: If Ite Jury or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Dulaney Memorial	valley Valley Gardens	200	7	Timonium	ı, MD
Ball	Depart Import any In		21. Signature of Fune discrete Licensee	$\text{Magle}  \begin{vmatrix} 1 & 1 \\ 1 & 1 \end{vmatrix}$	2. Name and Addre emmon Fundo: D W. Pado:	ss of Facility eral Home nia Road	of Dula Timoniu	ney Valley m, MD 2109	, Inc.
1	7 34		23a	the death. Do not ent	ter the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a consequence of):	myope	my			Year
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687		edical	d						
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	/		23d. Date of de Month	livery Day Year
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Division or Vital Records,	The law rate has be	Completed by					24a. Was ar autops perform	y prior to ned? death?	utopsy findings available completion of cause of 2 □ No
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Or.	Physic this c	은		ent 2 ER/Outpatier		4 □ Nursing Ho	me 5 Reside	ence 6 Other (Spe	city) MOSP (10
OU	ding i	tion:	1 Natural 5 Pending (Month, Day		Wor	k? Yes 2 ∐No	20d. Describe no	w injury occurred	
visio	Atten er deatl rector: by the	Certification:	-□ a : : : 6□ Could not be	ury - At home, farm, str c. (Specify)			28f. Location (Sti City or Town	reet and Number or Ri n, State)	ural Route Number,
	Ital or A rs after ral Dire	Cert							
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of the pasts of	f examination and/or in	th occurred at the tile nvestigation, in my	me, date and place, ppinion, death occur	and due to the ca red at the time, d	ause(s) and manner as ate and place, and du	s stated. e to the cause(s)
	To the within To the comp	×	29b. Signature and title of certifier		29c. Licens	e number	29	9d. Date signed (Mont	th, Day, Year)
			Marin		1950	505	No	Winder 2	0 2007
	P		30. Name and address of person who completed cause of d	eath (Item 23a) (Type,	Cunlle	IST DAY	Sow ist	0 21204	
	Sta		31. Date filed (Month, Dev. Year) 7 2007 32. Registr.	ar's Signature	Carle			9d. Date signed (Moni WIMINV D D Z1204	
	Registr	वा		- 1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Charles E. Chlan 12:55 P M Nov. 22 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore Towsop er 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 82 **Director** 219-10-6532 July 26 1925 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show r 28a-f show notified at Director MD 1 □Yes 🔏 □ No Baltimore Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ns 23a or must be r 205 Joppa Rd. #2103 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. Funeral USA 21204 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Myes 2 No If Yes, Give Year or Dates: \$43-\$46 1 Never Married 2 Married aftimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. à Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank C. Chlan Bertha Proger ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Angelos/son 11905 Greenspring Ave., Owings Mills, MD 21117
e of Disposition (Name of 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/27/07 Dulaney Valley Memorial Gardens Timonium, MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney VAlley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Fundamental Vice Licensee Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Syndrome **Physician** 51 veeks /Medical Due to (or as a consequence of): Examiner months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division or Vital Records, P.O. Box 68760, Co. Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 prity disense, Chronic Kidney disense, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed CIA betes COVO nany artery disease melli tue 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy piration preumonia Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 🗌 Yes 6 Other (Specify 6 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of conflier 29c. License number 29d. Date signed (Month, Day, Year) Cey; and November 22, 2007

0

State

31. Date filed (Month, Day, Year) NOV 2 7 Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles St. Balts. Md 21208

1 - For State Registrar

Physician

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	Examir		4a. Facility Name (If not institution, give Saint Joseph	street and number) Medical	Cente	4b. City, Town	, or Location of Deat TOW	h S O Ti	4c. C	County of Death Bal	timore
	Funeral Director		5. Social Security Number 6. Social Security Number 1 215–16–5264  Usual Residence of Decedent	ex 7. Age	e (In yrs. last bi 85	thday) If Under 1 Yea Months Day		(Month, L	irth Day, Year) 13,192	Cot	nplace (State or Foreign untry) ryland
	land ow		10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
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	the 28a-	Director	10e. Street and Number	J1 E	1.1	10f. Zip Code			10g. Citize	en of What Cou	untry?
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	ns 23	era	10 Harding Street	12. Was Decedent 8	ever in U.S.			necify Yes or N	lo- 14	4. Race - Amer	rican Indian.
	fter of item	Funeral	1 X Never Married 2 Married	Armed Forces? 1X Yes 2 ☐ N If Yes, Give	No	13. Was Decedent o	uban, Mexican, Puèr	to Rican, etc.)		Black, White	e, etc.
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9500-617	72 hours after death with the Maryland natural", or items 23a or 23a-f show dical Examiner must be notified at	ted	15. Decedent's Ed	ucation		Decedent's Usual Occ	cupation		16b. Kind	d of Business/I	
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and	9 6 _ >	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middl	e, Maiden S	urname)	
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saltimore,	ages 1 and 2 should bent of Health and Ment t: If item 27 is marked y or other traumatic e		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Removal from State	cemete	f Disposition (Name of ry, crematory or other p	lace) 11/2	24/07	20c. Loca	ation - City or 1	Town, State
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n D	permit. Pages 1 Department of H Important: If ite any injury or ot once.		Bryan W. Clar	Clara			fress of Facility Funeral Ho adonia Roa				
			23a. Part1. Enter the disease, or comp shock, of heart failure. List only	plications that caused	the death. Do	not enter the mode of d	ying, such as cardia	c or respiratory	arrest,		Approximate Interval Between
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	/Medical		resulting in deality	Due to (or as	a consequence	of):					
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,	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	of):					
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5	r this	2	27. Manner of Death	28a. Date of Injur	v 28b.	Firme of njury 28c. In	4 Linuising F	lome 5 Res			city)
5	affine fune fune	ţi	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)		/ork? □ Yes 2 □ No				
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5	tal or s atte at Dir ed in	Certification:	4 I Hornicide	building, etc	. (Бреспу)			City or 10	own, State)		
	To the Hospital or Attending Physician: The law requires the within 24 hours atter death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	Medical	29a. Certifier (Check only one)	ysician: To the best on the basis of and manner sta	examination ar	e, death occurred at the d/or investigation, in m	time, date and place y opinion, death occi	e, and due to the urred at the time	e cause(s) a e, date and p	nd manner as place, and due	stated. to the cause(s)
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	8%,		30. Name and address of person who described by the second			Type, Print) ER DRIVE,	TOWSN.	MARYL	AND 8	21204	*
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens, 37548 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DOUGHT Month **Physician** 23 2007 2204 /Medical 4b. City, Town, or Locetion of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 13+ evern Anne Arundel If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) May 22, 19 5. Social Security Number 6. 7. Age (In yrs. last birthday) **Funeral** Months Days 250-40-7788 Yrs. Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Co. r than "netural", or items 23e or 28e-f shoute Medical Examiner must be notified at Anne 1 ☐ Yes 2 No Hrundel sever Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 641 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours efter di Il Hygiene. other than "netural", or item Yes, specify Cuban 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 NO 1 □ Yes 2 □ No Baltimore, Maryland 21215-0020 Specify: Specify: ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use setired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Apostolic College (1-4or 5+) Elementary/Secondary (0-12) Foundation 10th permit. Pages 1 and 2 should be filed v Depertment of Health end Mental Hygie Important: If Item 27 is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be sallie 049W 2 edtord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WB+ARd, 7642 mD, haron 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ò 1 Surial 2 ☐ Cremation 3 Removal from State 11-29-0 Kandaelstown, MD. mem. King 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ed HIL 70 P.marc h Fitt, md, 21229 Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 0 Examiner Physician/Medical Examiner attending physician end for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, Due to (or as a consequence of): Due to (or as a consequence of): Division of Vital Records, P.O. To the Hospital or Attending Physicien: The law requires that the de within 24 hours effer death.

The Funera Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be deteched. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ANatural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tes 2 🗆 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2. Wedical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDUSE HOHWAY ARNAPOUS MALLYD NTAM E Day, Year) 32. Registrar's Signature 31. Date filed (Month, State Registrar

DHMH 16 Rev 6/95

Registrar

			Fiea	se Type or Prit			artment of H		•	•	
			1 - State Registrar Amend #889,			•			, ,	eg. No. 2 / / /	7 27550
			Decedent's Name (First, Middle)		J, 11/	21/01-	11		2. Date of Deat	th _	3. Time of Death
	Physici: /Medic		BRIDGET A	DEAN					Month NOVEMBE	R 25, 2007	
}	Examin		4a. Facility Name (If not institution	, give street and number)			4b. City, Town, or	Location of Death	•	4c. County of De	ath
			GREATER BALTIMO					ISON If Under 24 Hrs.	1 a B (B) #	BALTIMO	
	Funeral Director		5. Social Security Number	6. Sex 7. Ag	e (In yrs. I	ast birthday) 72 <sup>Yrs.</sup>	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 30,	Year) (	irthplace (State or Foreign Country) Ireland
	nector		216-36-3853 Usual Residence of Decedent			12			Jan. 30,	1933	TTICANTA.
ırylan	show	L	10a. State 10b. County			, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
he Mg	28a-f	ecto	MD BALTI	MORE	T	OWSON	405 75- 0-4-			0g. Citizen of What (	11
with t	t be n	Ď	10e. Street and Number 1655 MUSSULA F	POΔD			10f. Zip Code 212	86	'	USA	Southtry ?
d 21215-0036 filed within 72 hours after death with the Maryland	rial Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of H		pecify Yes or No-	14. Race - An	
after	or Ite mine	/ Fu	1 ☐ Never Married 2 ☑ Marri	Armed Forces? ied 1 ☐ Yes 2 ☐ If Yes, Give	No		1 ☐ Yes 2 ☐ Xio	Specify:	Hican, etc.)	Black, Wh	ite, etc.
<b>5-0036</b> 72 hours af	ural", Il Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			••			W	HITE
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nd effe	al Hyg l othe vent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle, I	Maiden Surname)	
Maryland d 2 should be file	Ment arked atic e	To	JOHN DOYLE			T			IA HOGAN		
Mar 12 sh	- E		19a. Informant's Name/Relations							r, City or Town, State	, Zip Code)
a -	E E		WILLIAM C. DEAN 20a. Method of Disposition	N/HUSBAND	20b. P	ace of Dispo	MUSSULA osition (Name of	1	JSON, MD Date	21286 20c. Location - City (	or Town, State
no ages	ent of It: If if yor o		1 🔀 Bunal 2 □ Cremation 4 □ Donation 5 □ Other (S				matory or other plac	1	1/2007	TITE F ENIDAE	E MD
altimore,	Department of I Important: If ite any injury or of once.		21. Signature of Funeral Service		MOR		MEM PAR  2. Name and Addre			HILLENDAL ON FUNERAL	HOME, P.A.
m e	a m c		> 71. The	el loten	car)	8	3521 LOCH				21286
			23a. Part1. Erter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	the death	. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	ysician		Immediate Cause (Final disease or condition resulting in death)	a. SEPTIC	EMIA						3 DAYS
	Medical aminer		resulting in death)	Due to (or as		ience of):					C DAVO
Lю	-tr	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. PNEUMC  Due to (or as		ience of):					5 DAYS
cuted	ansit	Examiner	that initiated events	<b>6</b> c.							
60, be executed	sician and burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):					
	F F	dical		d							
I <b>Records, P.O. Box 687</b> The law requires that the death certificate	attending p	Physician/Medio	IF FEMALE:	23c. If yes, outcome	pf pregna	ncy				23d. Date of o	elivery
BOX death cert	atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐Live birth 4 ☐ Pregnant a			□Ectopic pregnancy □ Other (specify)	/		Month	Day Year
P.O.	by the tacher	hys	9 Unknown	9□Unknown					1		
<b>S</b> #	signed by the a Id be detached f	by F	Part II. Other significant condition		ut not resu	llting in the u	nderlying cause giv	en in Part I.			to the cause of death?
Vital Records, sician: The law requires t	peen si	ted	ENCEPHALOP	V.T.H.T.						75	Probably 4 ☐Unknown
He aw	has b je 2 s	Completed							24a. Was a autops perform	sy prior t	autopsy findings available o completion of cause of
	certificate has birector, page 2 s		25. Was case referred to medical					00 Place of Page	1X Yes	2 □ No   1 🗓 Y	s 2 No
· VIII	s cert	o Be	examiner?	Hospital:	ent 2 □ I	ER/Outpatier	nt 3 DOA Oth	or.	th <i>(Check only on</i> ome 5 □ Resid	ence 6 □Other (S)	pecify)
n or	n. After this funeral dir	n: To	27. Manner of Death	28a. Date of Inju	iry	28b. Time o				ow injury occurred	
SIOI rendir	eath. :or: Ai the fu	atio	2 Accident investig	jation			M 1 □	Yes 2 □ No			
DIVISION OF VITA	n 24 nours arter death. ne Funeral Director: A pletely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 28e. Place of inj building, et	ury - At ho c. <i>(Specif</i> y	me, farm, sti	reet, factory, office		28f. Location (Si City or Town		Rural Route Number,
Spital	ours a neral filled		29a. Certifier 1 XCertifyin	ng Physician: To the best	of my know	wledge, deat	th occurred at the ti	me, date and place	, and due to the c	ause(s) and manner	as stated.
oH et	within 24 ho  To the Function  completely f	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner st		tion and/or in	nvestigation, in my	opinion, death occu	rred at the time, o	date and place, and d	ue to the cause(s)
Tot	To the comp	Ň	29b. Signature and title of certifier	1/10			29c. Licens	e number	2	9d. Date signed (Mo	nth, Day, Year)
			- Horse	~ [ heplo			D288	885		11/26/20	07
H	14		30. Name and address of person					20014 400 4		DE MD O	1 204
	Sta	te	HOWARD L. SIEGE 31. Date filed (Month, Day, Year)	11, M.D., 6/( 32 Registr	oar's Signa	CHARL ture	ES ST., F	KUUM 4004	, BALTIMC	ארטי ענון ארטער	1204
	Registr		NOV 2 7	2007 33 Registr	, XX	Ass	use)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Martin Derry 6:19 A.M Nov 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chesapenke Medical Center Bel Lount-Har ford If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. 6. Sex Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Fdreign Country) **Funeral** Days Hours 1**⊠**M 2□F 191-01-0611 Pennsylvania Director May 15, 1918 Usual Residence of Decedent 10c. City, Town or Location "natural", or ftems 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits (aunt) Harre de 1 ☐ Yes 2 No Directo Hartoid 10e. Street and Number 10g. Citizen of What Country? Robin # 742 21078 Hood United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Romal Marager permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Derr Martin LTON Virginia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Derry 40 Robin Hard Rd. # 742 Havre de Grace, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Di Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov: 26,0007 Forest Hill. injury o Evans Funeral Chapel 21. Signature of Funeral Service Licensee 22. Name and Address of Facility to Cremition Services - Bel Air 3 Newport Drive Farest Hill, Maryland 21059 23a. Part1. Enter the disease, or complications that caused the death. Do penter the mode of ping, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown gnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 (★No 24a. Was an funeral director, page 2 autopsy perform Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ **1**0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division or 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 □ No 24 hours after deat 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certific person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

NOV 2

2007

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Registrar's Signature

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31. Date filed (Month, Day,

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32. Registrar's Signature

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			For State	State of Maryla	and / Dep	artment of l ertificate of	Health a	and Mer		/ 11	07	37553
			Registrar     Decedent's Name (First, Middle, Last)	)			Boatti	2.	Date of Dea			3. Time of Death
	Physici /Medi		Roy Lloyd Daley	, Sr.					Month	Day 18. 20	Year	1:45P.
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location o		0 .	4c. County	of Death	1 0 1 0 1
		4	Stella Maris Ho			Timor					timo	
- 1	Funeral Director		5. Social Security Number 6. Se 195-60-9020	x 7. Age (In )  M 2□ F 51	rs. last birthday Yrs.	Months Days		Min.	Date of Birtl (Month, Day Ine 2	, Year)	Cou	pplace (State or Foreign intry) Amaica, WI
	/land row at		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or I	ocation						10d. Inside City Limits
	ne Mar 8a-f sh otified	ector	Maryland Baltim	nore	Woodl							1 ☐ Yes 2 📉 No
	ith with the 23a or 2 ust be n	Funeral Director	1146 St. Agnes	Lane		10f. Zip Code 212	07			10g. Citizen of N USA	Nhat Cou	intry?
P-m- 0036	pe mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	by Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	n Ü.S. 13	. Was Decedent of If Yes, specity Cul 1 ☐ Yes 2 X No	oan, Mexicar	gin? (Specify n, Puerto Ric	Yes or No- an, etc.)	Blac	ce - Americk, White	
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	ed wit ygien er tha	So.		1½ Years	Auto	Body T				Self-F		oyed
2007 ryland	And be file fental H ked oth	lo Be	17. Father's Name (First, Middle, Last) Leopold Daley					er's Name <i>(Fi</i> S Mi		Maiden Surnan	10)	
18, 2007 e, Maryland	nd 2 shorath and No. 27 is ma		19a. Informant's Name/Relationship (7) Angelita Daley	pe. Print) / Daughter	19b. Mai 4024	ing Address (Stree Hilton	t and Number	er or Rural R	oute Numbe	r, City or Town, Baltin	State, Zi	, Md 21215
~ ~	Pages 1 a ment of He ant: If Item lury or othe		20a. Method of Disposition  ★分Burial 2 □Cremation 3 □F 4 □Donation 5 □ Other (Specify)	removal from State	rbutus	position (Name of ematory or other pla Memori	al Pa	1/24°	A		s,Ma	ryland
NOVEMBER Baltimor	pe mit Depart Import an in		21. Signature of Funeral Service Licens	ee 4		22. Name and Addr						eral Home Md 21215
	44 (R)	egitr.	23a. Part1 Inter to dis ase, or complished, or he in failure. List only o	ications that caused the d ne cause on each line.							-1720 1130	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons	sequence of):						-	
8	Examiner	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):						-	
de	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	nogunna of):							
68760,	icate be executed physician and the burial-transit	dical E		d.	sequence or,							
. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 1000 pressures 10000 pressures 1000 pressures 1000 pressures 1000 pressures 1000 pr	etal death 3	□Ectopic pregnand □ Other (specify)	ру			I	ite of delive	very Day Year
ROY DALEY or Vital Records, P.O.	w requires that s been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the	underlying cause gi	ven in Part I.					the cause of death?
LEY	aw requ s been	Completed							24a. Was a	an 24b.	Were aut	topsy findings available
7 DAI al Re	<b>siclan:</b> The law certificate has t irector, page 2 s									med?	prior to co death? 1 ☐ Yes	ompletion of cause of 2 No
ROY Vita	Physiclan: this certifica	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	lospital: 1 ☐ Inpatient 2	P ☐ ER/Outpatie	ent 3 DOA Ot	h	of Death (C				
n or	ding Phys n. After this funeral dir	$\vdash$	27. Manner of Death  1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time	of 28c. Inju	ıry at ork?	28d		ow injury occur		ity) HOSPICE
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - A building, etc. (Spe	t home, farm, s		Yes 2□		Location (S City or Tow	itreet and Numb n, State)	er or Ru	ral Route Number,
	ospital of hours a nueral C		29a. Certifier  (Check only   1 Certifying Phy   2 Medical Exami	sician: To the best of my	knowledge, dea	th occurred at the t	ime, date ar	nd place, and	due to the	cause(s) and ma	anner as	stated.
	o the He ithin 24 or the From plete	Medical	29b. Signature and title of certifier	ner; On the basis of exam and manner stated.	ination and/or		se number	ath occurred		date end place, 29d. Date signe		
	⊢≯⊢ŏ						437	21			9/07	,
	~		30. Name and address of person who co	empleted cause of death (	Item 23a) (Type	, Print)	-	J		11//	401	
	<b>b</b>		DR. TARIQ MAHMOOI		NEY VAL	LEY RD.	TIMON	IUM, M	D 2109	93		
	Sta Registi	_	31. Date filed (Month, Day, Year) NOV 2 7 20	32 Registrar's Si	gnature	LEY RD.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 37554 State Registrar Amend 10gper Inf, C874, 12/20/07 TICertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 7:37 P.M November 21, 2007 Amarjit Singh Dipak /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 218-63-8449 Director 12, 1936 India Dec. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Funeral Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 11657 Drumcastle Terrace 20876 United States India 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: Asian Indian 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. item 27 is marked other than other traumatic event, th∈ M Attorney/Professor Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Natha Singh Maya Devi 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beena Kaur / Wife 11657 Drumcastle Terrace, Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Ind. Nov. 23, 2007 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Life Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Its only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician My ocardoal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying (1997) that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a the burial-1 Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has be 2 s autopsy perforn Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number November 21, 2007 DO0057455 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
NOV 2 7 2007

Sunil Saxena, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 0:56AM JEWEL DANIELS 71 7 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TAKOMA PRINCE GEORGES Adventist Washington lospita If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number **Funeral** Days Hours Min 10-16-1934 1 □ M 2 1 F 73 WASHINGTON, DC 204-26-8270 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No DAUPHIN HARRISBURG Director PA. 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 17103 USA 807 N. 16th ST. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Specify: AFRICAN-AMERICAN 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within : th and Mental Hygiene. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) HOMECARE HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be INEZ HAMILTON HAYWOOD RILEY ၉ permit. Pages 1 and 2 sh.
Department of Health and
Important: If item 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CONSTANCE DANIELS 5705 43rd AVE APT-B2 HYATTSVILLE, MARYLAND 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ARemoval from State INDIANTOWN GAP NATIONAL 11-26-2007 ANNVILLE, PENNA. 5 ☐ Other (Specify) 4 Donation D. HIBNER Name and Address of Facility MAJOR H. WINFIELD FUNERAL HOME 21. Signature | f Funeral Service Lice see NEHTANOL 704 N. FRONT ST. STEELTON, PENNA 17113 23a, Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im nediate Cause (Final dis and or condition resulting in death) Sensis Septic Physician /Medical Due to ras a consequence of) **Examiner** on Hernodialysis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit an cytopenia Due to (or as a consequence of) P.O. Box 68760, IE FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performe death? 1 ☐ Yes 2 No certificate 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11/17/2007 MD

State Registrar

DHMH 17 Rev 1/2001

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istrar's Signature

Takong Park, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

Please Type or Print in black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ADA DISTANCE November 23,2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE CIT BON SECOURS HOSPITAL BALTIMORE MD 8. Date of Birth (Month, Day, Year) Sept. 29, 19 (In yrs. last birthday) 1 □ M 2 🔀 F Yrs. 67 217-38-7807 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1XXYes 2 □ No Baltimore MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA 2523 Edmondson Avenue 14. Race - American Indian, Black, White, etc. African American 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) 12 nurse assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jimmy Spann Anna George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1113 Harlem Avenue; Baltimore, Maryland 21217 Sequoia Distance / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 11/30/2007 Randallstown, MD Wylie Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service License 638 N. Gilmor Street; Baltimore, MD ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final MYOCARDIAL INFARCTION disease or condition resulting in death) Due to (or as a consequence of): END STAGE RENAL DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PULMONARY EDEMA

Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4⊡Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2▼ER/Outpatient 3□ DOA 1 ☐ Yes 1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Physician** /Medical Examiner physician and is the burial-tran Division or Vital Records, P.O. Box 68760. attending p

To the Hospitallor Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical Certification: To

**Physician** 

Examiner

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23.

other than "natu vent, the Medical

7 is marked othe traumatic event,

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Important: if ite
any injury or ot

Baltimore, Maryland 21215-0036

Director

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Director:

State Registrar 27. Manner of Death 1 Natural

2 Accident 3 ☐ Suicide 4 Homicide

determined

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

29c. License number D59290

29d. Date signed (Month, Day, Year) November 23 2007

person who completed cause of death (Item 23a) (Type, Print) Bethin Adjei, MD

and manner stated.

Battimore, MD 21223

Baltimore St.

State of Maryland / Department of Health and Mental Hygiene 0 17 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NO MBER 26. 2007 **Physician** Jeanne M. Emala 7:30A M /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 8/10/1925 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 ▼ F 213-20-9375 82 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits show Department of Health and Mental Hygiene. Important: If Hem 27 Is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumattc event, <u>the Medical Examiner must be notified at</u> 1 ☐ Yes 2 No Director Timonium MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21093 2300 Dulanev Valley Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White δ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Nursing Reg. Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Vogt Frances Charles Keagle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900 Chantilly Ct. Forest Hill, MD Joseph F. Emala/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 11/28/07 Towson, Maryland Hilltop Serv. Corp. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Towson, Maryland 21. Signature of Funeral Service LR Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown ASPIRATION PNEUMONIA page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣No 24a. Was an DEMENTIA autopsy performed? 1☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Unpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ✓ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 ☐ Accident 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D.

32. Registrar's Signature

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MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Jeannette Susan Fitzwater NOV 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital Baltimore St. Agnes N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M **X**□F 215-08-8073 37 Director May 23, 1970 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the them 27 is marked other than "natural", or Items 23a or 28a-f show ant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show ant: if Item 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo MD Baltimore <u>Baltimore</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5659 Selford Road 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jonnie Dwight Ingram Frances Joline McGee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Fitzwater - Husband 5659 Selford Road, Baltimore, MD 21227 20b. Place of Disposition (Name of Gremetery crematory or other place)

Haven 20c. Location - City or Town, State 20a. Method of Disposition IX Burial 2 ☐ Cremation 3 ☐ Removal from State 11-21-2007 Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) Memorial Park 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Preumonia **Physician** 5 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner obstruction s days Bowel Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed crohn's disease 10 years severe Due to (or as a consequence of): Physician/Medical attending properties as Box 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2☑No Division or Vital Hospital or Attending Physician: Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier , MO Faren OP19513 NOV 18, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Ave. S. Caton Baltimore, MD 21229 Fazeli, MO, 900 Parasteo

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37559 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 3:15 P.M **Physician** ORP 25 Õ ARGUERIT /Medical 4b. City, Town, or Location of Death 4c. County of De 4a. Facility Name (If not institution, give street and number) Examiner BURNIE, ARUNDEL HEALTH NORTH If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 M 2√2 F 86 Yrs. 09-08-1921 WV 233-46-3473 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show notified at 1 ☐ Yes Mo No Funeral Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or ury or other traumatic event, the Medical Examiner must be r U.S.A. 21061 404 Vernon Court 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White Completed by 3€ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iva Lockhart 2 Alvin Honaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>2607 Chapel Lake Drive #301</u> Gambrills, MD 21054 Ms. Norma Hasse / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. Burial 2 □ Cremation 3 □ Removal from State 11-30-2007 Brooklyn, MD Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Srv 21. Signature of Funeral Service Licensee sense 2nd Ave SW Glen Burnie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROS S Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PERTENSI if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? in the past 12 months 1 Tyes 2 No 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 nknown LIBRILLATION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Yo 24a. Was an autopsy performed Yes 2 1∏ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical ( 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

SICHARD

31. Date filed (Month, Day, Year)

NOV 2

17 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRAIN

32. Registrar's Signature

DOZ519

TOWERS

29d. Date signed (Month, Day, Year)

GLEN BURNIE

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2007 1 - For State Registrar 37560 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 20, 2007 10:34A M BOYD LEE FREELS /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Nov. 11, 1 Gilchrist Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 XX 2 F Yrs. 514-01-6184 90 0kTañoma Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. The Mucical Examinar must be mutified at 1 Yes 2 XX Baltimore Maryland Glen Arm Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4306 Meadowcliff Road 21057 USA by Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 1 0 0 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be fitted within 72 hours after nand Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Petroleum Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Freels Elsie Shull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr sny Injury or other traum 90058. Marylee Hurst Freels Wife 4306 Meadowcliff Road Glen Arm Maryland 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Dulaney Valley Memorial Gardens 11/24/07 Timonium, Maryland 4 Д Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or com-shock, or heart failure. List only dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Multiple Stroke years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Atrial Fibrilation attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 certificate has been signi rector, page 2 should be 1 Yes XXNo 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes X2X No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner? X X No Other: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence XXOther (Specify) HOSPice 27. Manner of Death
XX Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29b. Signature and this of certifie 29c. License number 29d. Date signed (Month, Day, Year) D25205 November 20, 2007 30. Name and address of person completed of eath (Item 23a) (Type, Print) 0 W Anthony Riley MD 6/01 North Charles Street Towson, Maryland 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 7 Registrar

DHMH 17 Rev 1/2001

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Funeral Director		5. Social Security N		6. Sex	2 F	7. Age (In y	rs. last birth	day) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	3. Date of Bir Oct. 1	th(MM/I	985 For	Birthpla eign Countr	North North Carolina
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Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	2 Accident 3 Suicide	6 Cou	stigation ld not be		e of Injury -			et, factory, o			c. 2	or Town.	State)	and Number o		Route Number, City
D he Hospital in 24 hours he Funeral pletely filler	cal Ce	4 Homicide 29a. Certifier (Check only one)	Certifying P	hysician:	To the bes	Local S t of my know	wledge, dea	ith occur	red at the t	ime, da	te and pla	ice, and di	ue to the cau	se(s) ar	nd manner as ace, and due t	stated.	-
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10		30. Name and add				se of death ( Medical E	_	r 11	1 Penn S	Street	, Baltim	ore, ME	21201				
Sta Registr		31. Date filed (Mon	th, Day, Year)	2007	32 Re	gistrar's Sig	gnature	Cons							•		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Philip C. Fraley 此久 Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death ak Daltimore are If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) Days 1 **X**M 2 ☐ F 168-12-8015 87 March20,1920 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count Baltimore 1 ☐ Yes 2X No Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 2602 McComas Avenue 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛂 No White Specify 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Spiral Welder Operator Metal 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Philip W. Fraley Margaret Curtis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Fraley /son 946 Bird River Beach Road Balto. MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Cemetery 11/26/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral 3 y dice beens Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part I. Enter the disea shock, or heart failure nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on pach like. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ardiac Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 💇 No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

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certificate Physician:

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To the Hospital of within 24 hours af To the Funeral D

filled in

certificate be executed

Box 68760.

P.O.

or Vital Records,

Division

Department of Health a important: If Item 27 Is any injury or other tra

Physician

Examiner

**Funeral** 

Director

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"natural", or item: ledical Examiner n

27 is marked other than "natu traumatic event, the Medical

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

Baltimore, Máryland 21215-0036

Takey Phili

Director

Funeral

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Completed

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/Medical

10a. State

MD

Examiner attending physician for use as the buria Physician/Medical ed by the signed by t d be detach þ Completed page 2 s funeral director, Be Certification: To

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

5 Pending investigation

6 Could not be

25. Was case referred to medical examiner?

1 ☐ Yes

27 Manner of Death

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

(Check only one)

Natural

2 No

24a. Was an autopsy

perform

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier NOUYER

who c

Hospital:

29c. License number 00065094 29d. Date signed (Month, Day, Year) 11/22/07

State Registrar

Medical

9000 Tranklin 32. Redistrar's Signature 31. Date filed (Month,

and manner stated.

npleted cause of death (Item 23a) (Type; Print)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-09073 State of Maryland / Department of Health and Mental Hygiene 37564 2007 **UNK UNK** Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 23, 2007 2312 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 1 **Baltimore** University Hospital 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 5. Social Security Numbe 6. Sex **Funeral** Min. Davs Hours Months Country) MARULAN Director 2 1 M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No 28a-f show s 23a or 28a-f shov e notified at once. Director of What Country? 10g. Citize 10f. Zip Code 10e. Street and Number Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after death wit Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be 1 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes Specify: Yes 2 No specify: If Yes, Give Year Divorced Widowed è 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KOBER (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Removal from State X Burial 2 Cremation Other Specify Donation 5 UNERAL HOME 22. Name and Address insee of Funeral Servic Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Causa Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial 23d. Date of delivery Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy Day 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? has 2 No ✔ Yes 2 ✓ Yes Ine Hospital or Attending Physician; Ti in 24 hours after death. Ine Funeral Director; After this certifica pletely filled in by the funeral director, pa 26 Place of Death (Check only one) 25. Was case referred to medical Be Other 4 examiner? Other DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Nov 23, 2007 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject shot Certification: 2223 hrs Yes 2 V No Natural Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 1000 Block of Boyd Street , Baltimore , MD 3 Suicide determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 24, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 1 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year NOV 2 7 20 State Registrar

Robert Gray

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Mathilde Gruby 8:40a <sup>™</sup> Leona November 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Halethorpe Baltimore 3063 Freeway If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Months Hours 220-14-8202 10/25/1925 Maryland Director 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County a or 28a-f show t be notified at 1 ☐ Yes 2 XNo Directo Maryland Halethorpe Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a 3063 Freeway 21227 United States Examiner must Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 No Specify: 2 White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Dekatow Grace Warnick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health as Important: If item 27 is any Injury or other trau once. Michael D. Gruby / Son 3063 Freeway, Lansdowne, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 11/21/2007 Elkridge, Maryland 21. Fign ture of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue 23a. Part1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC RENAL Physician /Medical Due to (or as a consequence of): KIDNEM DISEASE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform

page 2 s director. Be Certification: To funeral After after death.

Director: Al

2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

1 Yes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide

Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

4 ☐ Homicide

29a. Certifier

29c. License number D16354

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

900 CATON AVE BALTIMORE AGNES COLE 31. Date filed (Month, Day, Year)

State Registrar

Medical

2007



Hospital or Attending Physician:

filled in by

within 24 hours a To the Funeral I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 37566 State of Maryland / Department of Health and Mental Hygiene [] [] 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year GLADMON *tudrey* 1:50 PM NOV 23 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Pasadena Anne Arundel Oak Lodge Senior Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F 93 July 23, 577-10-0653 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Anne Arundel Millersville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21108 USA 8263 Ahearn Dr 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Yes 2 1 ☐ Yes 2 ŽNo Specify: White 3 Widowed 4 Divorced ear or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Hovermale Jacob Bernhard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. June Argubright/ Daughter 8263 Ahearn Dr.; Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition National Memorial Park Nov. 27, Falls Church, VA

22. Name and Address of Facility 1 2nd Ave. SW, Glen Burnie, MD 21061 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of her Serve Licensee Singleton Funeral and Cremation Services; M01411 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition semile Yearts disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it is a property to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? 2 P. No pneumonta 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 214 No Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

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Important: If ite
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**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene.
Ant. If item 27 is marked other than "natural", or Items 23a or 28auny or other traumatic event, the Medical Examiner must be notifi

Baltimore, Maryland 21215-0036

Completed by Funeral Director

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physician sthe burial been signed by the s certificate has be rector, page 2 s After within 24 hours after death

To the Funeral Director:
completely filled in by the i

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specific ဥ 1 Tes 2 No 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

700 GEIDERD #204 Catonsville, MO 218228 m.D BENTAMIN

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



			epartment of Health and M	ental Hygie	ene
		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death	3. Time of Death
Physici /Medic		Joseph W. Green, Jr.		NOVEMBE	R <sup>Da</sup> 19, 2007 01:46 ам
Examir	er	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER	4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	Months Days Hours Min.	8. Date of Birth (Month, Day, ) Aug. 4,	
and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town		Aug. 4,	10d. Inside City Limits
e Maryl a-f sho iffied at	ctor	3. 3. 3.	arkville		1 ☐Yes 🔏 ☐ No
with the	I Director	10e. Street and Number 2467 Woodcroft Road	10f. Zip Code 21234	100	j. Citizen of What Country?  USA
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id be fillental Fred oth	To Be	17. Father's Name (First, Middle, Last)  Joseph W. Green, Sr	18. Mother's Name		iden Surname)
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tem 27		Ruth Daiker Mother  20a. Method of Disposition 20b. Place of	2467 Woodcroft Road Disposition (Name of D		re, Maryland 21234
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parmit. Pages 1 and 2 Department of Health of Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Burgee-Henss-Seitz	Funeral 1	
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my knowledge, 2 ★ Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, a lor investigation, in my opinion, death occurre	nd due to the caused at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
To with with To I	2	29b. Signature and title of certifier  Mitchell Sourcests	29c. License number	29d	Date signed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )
5		30. Name and address of person who completed cause of death (Item 23a) (The Schwicht Costs)	Shorth Charles St	Soite	SJO TOUSUMM
Sta Registra		31. Date filed (Month, Day, Year)  Solve 1 2 32. Projector's Signature	Lecall o		
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Director		7. Age (1	In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs Hours Min.		( Xearh	Birthplace (State or Foreign Country) Sh DC
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Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at order.  To Be Completed by Funeral Director	al Status lever Married 2 ☐ Married Vidowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	I□Yes <b>2</b> € No	Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Al Black, W Specify: B	
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Nand Short I said that I short	ormant's Name/Relationship (7 eta Chatmon/	ype. Print) Daughter	1103	Pine L	and Number or R	keek, M	er, City or Town, State 1D 20607	e, Zip Code)
Baltimore,  of crimit. Pages 1 ar  Operatine of Hea  Operatine of	hod of Disposition Burial 2 □Cremation 3 □ Donation 5 □ Other ( <i>Specify</i>		20b. Place of Dispo cemetery, cren Resurre	natory or other pla ction C	T.		20c. Location - City	MD
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5 30. Nam Dan	e and address of person who diel Alexando	er 3001 H	ospital	Drive (	Cheverly	v. MD 2	0785	
State 31. Date Registrar	filed (Month, Day, Year)	1 32 ⊯edistrar's	s Signature				- I.V.J	

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens 37569 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month MARY **Physician** GOETTUNG 2007 YY 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harwood

If Under 24 Hrs.
Min.

8. Date of Birth (Month, Day, Year) Mandrin Hospice House Anne Arundel 5. Social Security Number If Under 1 Year 6. Sex Birthplace (State or Foreign Country).
 VICGINIA 7. Age (In yrs. last birthday) Funeral Sex 1□ M 25√F Months Days Yrs. 225-40-0299 Director 73 July 26,1934 Usual Residence of Deceden Pages 1 end 2 should be filed within 72 hours after death with the Merylend nent of Health and Mental Hygiene. not of Health and Mental Hygiene. not: If Item 27 is marked other then "natural", or items 23e or 28e-f show 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or items 23e or 28e-f show other treumatic event, the Modical Examiner must be notified at Maryland Anne Arundel 1 ☐ Yes 2 No Directo Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Benefield Road Suite 115 Completed by Funeral 21146 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 TyNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) A.A. Co Police Dept. Central Records 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moah Abraham Mary Edna Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Jones Department of Health mportant: if Item 27 4411 Sharon Dr. Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State injury or Lakemont Cemetery 11/26/07 Davidsonville,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Rd Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 6 mos Examiner Physiclan/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed ettending physician and for use as the buriel-transit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 16 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hes 1 ☐ Yes 2 ☐ No 1 Tes MANDRIN 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: ၉ Other: 4 Nursing Home 5 Residence 6 Dother (Specify) # 05 PICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: House. 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hours
of the Funerel Discompletely fille 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as steted.
2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 21438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL J. La LENTH WY YY (1) LENSE HIGHWAY ANNAPOLIS 31. Date filed (Month, Day, Year) 32. State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 07:22 P M NOV. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 → M 2 □ F Months Hours 44 Director 219 88 0524 JAN.6,1963 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Y☐Yes 2☐No MD. N/A BALTIMORE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with a or 21213 LAFAYETTE AVE 1312 E. 'natural", or items 23a dical Examiner must t USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within:
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "n any injury or other traumatic event, the Medione. Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION LABORER 7TH18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GERALDINE SMITH ဂ္ ROBERT LEE HUGHLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBIN HUGHLEY (sister) 1312 LAFAYETTE AVE. BALTO, MD. 21213 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LORRAINE PARK CEM. nov. 28, 2007 BALTO, MD. Sinature of Funeral Service License CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** BRAIN ANOXIC INJURY /Medical Due to (or as a consequence of) Examiner SEIZURES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine PULMONARY EDEMA burial-trar Due to (or as a consequence of) attending physician for use as the buria Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed INTRAVENOUS DRUG ABUSE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy perform HEPATITIS 2 No 1 ☐ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 XInpatient 2 ER/Outpatient 3 DOA 2 After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred I or Attending F after death. I Director: After i Certification: (Month, Day Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled it Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Tare MN NOV, 21, 2007 RES 000 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TARER ABOU-KHAMIS; 5601 LOCH RAVEN BLVD, BALTIMORE, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOV 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Jown, or Location of Death 4c. County of Death Examiner Dea 12 tta 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. ial Security Number **Funeral** 1**2** M 2 □ F Days Director 0/6/ Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Eve Arrhed Forces? 1 DYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced þ Specify: Completed Baltimore, Maryland 21215-0 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 19 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fallston MD 21. Signature) of Funeral Service License 22. Name and Address of Facility Forest Hill HUZIUS on Services-Bestir 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. Lis only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 20 minutes /Medical Due to (or as a consequence of): Examiner ronari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: been signed by the attendin should be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hamlin, Koter autopsy performed? Yes 2 No certificate has 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 □ DOA ပ 28a. Date of Injury (Month, Day Year) 28b. Time of injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending P within 24 hours after death. To the Funeral Director; After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI) Name and address of person who completed cause of death (Item 23a) (Type, Print) esapeake D1 .520 U 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep			2007	37572
_			riegistrai	rtificate of Death	Reg 2. Date of Death	J. No. 2 U U /	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Kerrie Ann Hohreir	1	Month	Day Year	5:25 A. M
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	November	20, 2007 4c. County of Death	J:23 A.
	Examin	ier	Gilchrist Hospice Center	Towson		Baltimor	e e
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.     Months Days Hours Min.	8. Date of Birth (Month, Day, )	rear) Count	ace (State or Foreign
ı.	Director		216 17 8922   1 M 2 X F 33 Yrs.		May 28,	1974   Mary	land
	land ow		10a. State 10b. County 10c. City, Town or L	ocation		10	0d. Inside City Limits
:	a-f sh	ţ	Maryland Baltimore Catons	ville			1 ☐ Yes 2 No
	or 28,	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Count	ry?
	ath w	la	1062 Craftswood Road	21228		U.S.A.	an Indian
	er de items ner m	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ☑ Married  1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - America Black, White, e	
5	illed within 72 hours after death with the Maryland Hygiene. Hyan "natural", or items 23a or 28a-f show ther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	If Yes, Give  3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 No Specify;		Specify: Whit	te
2-003c	natura Ilcal E	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	ina 1	6b. Kind of Business/Ind	ustry
V	ne. nan "i	d d	Elementary/Secondary (0-12)   College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	9	Veteranari	ion
7	Jed w Jygiel Iher tl		12th Rec	eptionist 18. Mother's Name	e (First, Middle, Ma		Lali
а По По	d be t ental h ced of	9 Be	Rodney Andrew Galford		Houck	,	
<u> </u>	shoul and Ma marl	은	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Rui		City or Town, State, Zip	Code)
Š	and 2 salth a 127 is er trai		Jason Hohrein / Husband 1062	Craftswood Road	Catonsvil	lle, Marylaı	nd 21228
ore	of He if item		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State	position (Name of ematory or other place)	Date 20	Oc. Location - City or To	wn, State
Saitimore	tment tant: tant:	1 0	4 □ Donation 5 □ Other (Specify) Bayview		55.50	Baltimore, N	
Da D	permit. Pages 1 and 2 should be blied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	. ,	Inameroush 4	001 Ritchie Highwa	y Baltin	ral Service more, Maryla	, P.A. and 21225
	20 P		23a. Part1. Enter the disease, accomplications that caused the death. Do not e shock, or heart failure. Ist by one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition	SARCUMA			2005
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
200	25 M E	Ē	Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury				
<b>A</b>	cuted nd ransit	Examiner	that initiated events c.				
6/00,	certificate be executed ding physician and ise as the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
200	icate t physic s the b	dical	d				
e xog	leath ceruitic attending p	Physician/Med	IF FEMALE: 23c. if yes, outcome pf pregnancy			23d. Date of delive	ry
ď	death e atten d for u	icial	in the past 12 months?  1 Nee 2 Months?  4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
5	that the ed by the detache	hys	9 ☐ Unknown 9 ☐ Unknown		T		
(V)	w requires that the di been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to th s <b> </b>	
ecord	requires to been signe hould be (	Completed				7-	
Lec Lec	2 2 2	mple			24a. Was an autopsy perform	prior to cor ed? death?	psy findings available npletion of cause of
	in: The ificate ha or, page	e Co	25. Was case referred to medical	26 Place of Dea	1 Yes 2 h (Check only one	No 1 ☐ Yes	2 No
>	ysicia is ceri	To B	examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Lau		nce Dother (Specify	HOSPICE
0	ng Ph fter th neral		27. Manner of Doath 1. Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe hov	w injury occurred	
Vision	tendl eath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be determined contained by the country of the cou	M 1 Yes 2 No	20f Location (Ctm	eet and Number or Rura	I Pouto Number
2	al or Attending is after death. Il Director: After din by the funer.	Certification:	4 Homicide determined building, etc. (Specify)	areet, factory, office	City or Town,		r noate Namber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	o the vithin (or the omple	1	COL C'	29c. License number	29	d. Date signed (Month,	Day, Year)
}	->-0		) (DEX))~~	D64395	N	NVEMBER 7	2007
	Ð		30. Name and address of person who completed cause of death (item 23a) (Type	e, Print)	,,,,,	V- WILLIAM V	1
	مل		DANIEUE DOBERMAN, MO 6565N C	HARLES ST, SWITE	209 BAL	TIMERE, M	0 21204
	Sta Registi	ate rar	30. Name and address of person who completed cause of death (Item 23a) (Type DANIEUL DOBLIMAN, M. OSTOSN C. 31. Date filed (Month, Day, Year) 2007	sele:			

DHMH 17 Rev 1/2001

2007

26,

NOVEMBER

HUMAN

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Howard John Hairsine Month **Physician** November 23, 2007 9:31P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Baltimore - Gilchrist Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** XXX 220-24-0477 78 June 12, Balto, Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9502M Amberleigh Lane 21128 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. XXX es 2 No If Yes, Give Year or Dates: 51-53 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXIo Specify: White Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custom House Painter Woodberry Const. Co. 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas J. Hairsine Ruth Virginia Fogle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Rachel Hairsine (Wife) 9502M Amberleigh Lane Perry Hall, MD 21128 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State Warial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial 11/28/07 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eurgee-Henss-Seitz Funeral Home, 2631 Falls Road Balto, MD 2121 21. Şignature of Furnial Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** earli disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner 101 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical 33 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) signed by the a I□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

6701 N. Charlest.

30. Name and address of person who completed seuse of death (Item 23a) (Type, Print)

32. Registrar's Signature

5205

Bolto Md 21208

November 24, 2007

			For State	State of Ma	ryland /	Department of			ental Hy	giene		
			Registrar			Certificate	of Deat			Reg. No.	2007	3. Filme of Death 5
	Physic	ian	Decedent's Name (First, Middle, La	ast)				2	<ol><li>Date of De Month</li></ol>	eath Day	Year	3. Time of Death
	/Medi		Elizabeth Harbi	n					11	19		10:30 A <sup>M</sup>
	Exami		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Tov	n, or Location	on of Death		4c. (	County of Death	
			Upper Chesapeak	e Medical C	enter			Marylan	d	Н	arford	
-	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last	Months D	ear II Und		B. Date of Bir (Month, Da	th		place (State or Foreign
	Director		219-10-9580	1□M 2 <b>½</b> F	85	Yrs.	2,0 11001		12/26/			h Carolina
_	P .		Usual Residence of Decedent									
	rylar how		10a. State 10b. County		10c. City, To	own or Location					•	10d. Inside City Limits
	n the Marylan r 28a-f show notifled at	cto	MD Baltim	ore	Kind	sville						1 □Yes 2 No
	vith the	ire	10e. Street and Number			10f. Zip Co	de			10g. Citiz	en of What Coul	ntry?
	h wii	a	7152 New Cut Ro	ad		210	87			U.S	S.A.	
	filed within 72 hours after death with the Maryland Hygiene. Hydiena "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Decedent If Yes, specify		Origin? (Speci	fy Yes or No		4. Race - Americ	
5 %	after or ite		1 ☐ Never Married 2 ☐ Married	1 □ Yes 2 X No	0				cari, etc.)		Black, White,	etc.
03	al", c	b	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 <b>X</b>	No Spec	ту:			Specify: Whi	.te
1030 an	2 ho natur	Completed	15. Decedent's E (Specify only highest gi	ducation	16	Sa. Decedent's Usual O	ccupation			16b. Kin	nd of Business/In	dustry
20 2	d within 72 ho giene. r than "natu the Medical		Elementary/Secondary (0-12)	College (1-4or 5+	)	(Give kind of work d life. DO NOT use re	etired)	nost of working		-		
5 2	filed with Hygiene ther than	E	12		<u></u>	Homemaker				0,	wn Home	
7	othe /ent,	Be	17. Father's Name (First, Middle, Las	t)			18. Mo	other's Name (	First, Middle	, Maiden S	Surname)	
<u>a</u>	lid by lents	TO E	Roddie Palmer				_   F	thel Do	ockins	•		
<u></u>	nd 2 should be filed v Ith and Mental Hygie 27 is marked other t traumatic event, th	-	19a. Informant's Name/Relationship	(Type. Print)	1	9b. Mailing Address (St					Town, State, Zip	Code)
11/19/07	nd 2 allth a 27 is r tra	١.	Joe D. Harbin	(son)		7900 Old H	rford	l Poad	D-1+	imor	o Morrel	and 21234
0-0	is 1 and 2 of Health Item 27 i		20a. Method of Disposition	(SOII)	20b. Place	of Disposition (Name of tery, crematory or other	f COLU	Dat	te Dail	20c. Loc	cation - City or To	own, State
-0	ages ent of t: If It		1 Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		1			11/24	/2007	71	J	
1	it. P		21. Signature of Funeral Service Lice	• •	Hario	ord Memoria						
Ba	permit. Pages Department of Important: If I any injury or once.		E FO									Home, P.A.
			23a. Part1. Enter the disease, or cor	plications that sourced t	ha dooth D						, Maryla	and 21087 Approximate
			shock, or heart failure. List only	y one cause on each line	e.	o not enter the mode of	dying, such	as cardiac or i	respiratory a	rrest,		Interval Between Onset and Death
	Physician	Ì.	Immediate Cause (Final disease or condition resulting in death)	a. Coro	NAN	Anten	1 2	)LOCA!	se			
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	e of):						
	LAdimine		Sequentially list conditions.	b								
_	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	e of):						
	ecute Ind trans	am	that initiated events resulting in death) Last	c							- 11	
108	e exi	ũ	resulting in death) Last	Due to (or as a	consequenc	e of):						
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) Box	leath certiff attending I for use as	an/l	23b. Was decedent pregnant	23c. If yes, outcome p 1□Live birth 2		ath 3⊡Ectopic pregn	ancv			2	3d. Date of deliv	,
0	dea ne att	Sicie	in the past 12 months? 1 ☐ Yes 2 ☑ No.	4□Pregnant at ti 9□Unknown							Month	Day Year
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全草	quire on sig uld b	D D							1 🗆	Yes 2	] No 3 ☐ Prol	pably 4 nknown
Reco	law re as bee 2 sho	Completed							24a. Was	an	24b. Were auto	opsy findings available
38	sician: The law certificate has b irector, page 2 s	ᇤ		····						ormed?	prior to co death?	mpletion of cause of
17 E	n: T ficat or, pa		25. Was case referred to medical	1					1 Yes	2 2 No	1 □ Yes	2 □ No
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C F		ion	1 → Natural 5 ☐ Pending	(Month, Day			Injury at Work? 1 ☐ Yes 2		d. Describe	now anjury	occurred	
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≳≧	or A offer Direction by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	iami, street, ractory, or	100	20	City or To	wn, State)	i wamber or nar	ar noute truttiber,
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	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medical Exa	miner: On the basis of a	examination	and/or investigation, in	my opinion,	death occurred	d at the time,	, date and	place, and due t	o the cause(s)
	To the I within 24	Med	29b. Signature and title of certifier	and marrior state	5u.	29c. Lie	ense numbe	er		29d. Date	e signed (Month,	Day, Year)
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	(10/		30. Name and odress of person who	completed cause of dea	ath (Item 23a	a) (Type, Print)	3000 L		21	1 -	ma	1014
			31. Date filed (Month, Day, Year)	An III.	's Signature	pper Chesc	year	epr.	JU-	the f	11100	HUIT
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 7:51 November 25 2007 HARDY KALYH MILAGRO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner reater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 11/25/2007 ME Director NONE Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County 28e-f show must be notified at 1 Yes 2 □ No BALTIMORE Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code or Itams 23a or 21206 USA 4411 MORAVIA ROAD, APT. 4 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Examiner Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 √2 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: 2 BLACK 3 Widowed 4 Divorced "natural". Be Completed b 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) INFANT INFANT 0 and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) SHYASIA HARDY UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PATHOLOG 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State permit. Pages Department of Important: If it any injury or o GREEN \* 4 ☐ Donation 5 ☐ Other (Specify) MOUN 22 Name and Address of Filicility 21. Signature of Funeral Service Licensee Lovaco NIM AND DONS CO. MONKTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -5H2 Pnysician PREMATURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PREMATI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 🗀 Yes 2 | No page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No ANOMIA 24a. Was an this certificate has autopsy performed SEVENTE METABOLIC AND 1 Yes 2/ No Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification; To Inpatient 2 ER/Outpatient 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation filled in by the Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a t. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number who completed cause of death (Item 23a) (Type, Print) PANE MARIA 31. Date filed (Month, Day, Year) State NOV27 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3757 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Felipe C. Inocencio 2001 3:30 pM 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Samaritan HOSPITAI If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days M 2 F Philippine Director August 24, 1927 214-64-3217 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2420 Woodcroft RD. 21234 United States Of America 12. Was Decedent Ever in U.S Armed Forces 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Guban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Specify: Asign 2 No Baltimore, Maryland 21215-0036 1 🗆 Yes Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Morgan States University Budget Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Valeriano Inocencio Cauaresma ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Kilbeggan Green Nottingham Maryland 21236 Philip Inocencio-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 11 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department o Important: If any injury or Moreland Nov, 28, 2007 Parkville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EVANS FUNERAL CHAPEL & CREMATION SERVICES 8800 Harford Rd. Parkville, Maryland 21234 cottice coms 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition acute myocardial infarction Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in relief cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ renal disease 1 Yes 2 No 3 Probably 4 Unknown Completed mellitus 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ₺ No 24a. Was an ate has page 2 s performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation s after dea...
eral Director: A'
v filled in by the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES -000 22 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Baltimore 5601 Loch Raven Natallia Maroz 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** NOVEMBER 23, 200 Catherine Patricia Irvin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Towson Baltimore Saint Joseph Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 09/19/19/31 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Mary Tand 1 □ M 2 🕇 F 76 216-28-4577 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 ▼Yes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21214 5507 Elsrode Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💆 No Specify: þ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Catherine Heffernan John Joseph Watts, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5507 Elsrode Avenue, Baltimore, MD 21214 John Irvin, Sr. , Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland Gardens of Faith 11/26/2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses 5305 Harford Rd. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): INFECTION URINARY TRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner LEUKEMIA Due to (or as a consequence of) IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 A No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 250 No 24a. Was an autopsy performed? 2 No 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Certification: To 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide Medical

The law requires that the death certificate be executed as the burial-transit Division or Vital Records, P.O. Box 68760, attending physician nse detached Hospital or Attending Physician: 24 hours after death. Director: within 24 hours aft To the Funeral Di completely filled in within 2

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydjene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medical

Examiner

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D41410

State Registrar

M. D. 76 32 Registrar's Signature TOGINDER [...] MEHTO

7601

mehla m.o

29d. Date signed (Month, Day, Year)

901

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOWSON, MARYLAND OSLER DRIVE

31. Date filed (Month, Day, Year) NOV 2 7

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician Aquita Jackson 22 2007 305A. Arlene /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 5218 Cuthbert Ave Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🔀 F 19 50 MD 218-56-0862 Director 57 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at Baltimore NA X ☐ Yes 2 ☐ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21215 5218 Cuthbert Ave Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ural", or item Black, White, etc. Never Married 2☐ Married 1 ☐ Yes ♀☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sinai Hospital Unit Clerk 12th grade 2yrs 18. Mother's Name (First, Middle, Maiden Surname) traumatic event. 17. Father's Name (First, Middle, Last) Be Hennietta Winder 2 Robert G. Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 5218 Cuthbert Ave, Baltimore, Md Pearl Rooks-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot XXBurial 2 ☐Cremation 3 ☐Removal from State 11/28/07 Baltimore Co, Md Woodlawn 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, wille Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (onas a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to to: Examiner 0 certificate be executed that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE: use yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy o in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached Division or Vital Records, P.O. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cidne WIL 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an was and autopsy performed?
Yes 2 14 No has certificate 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 100 ၉ 1 Tes this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier ND

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of per

UUU 32. Registrar's Signature

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use of death (Item 23a) (Type Print

who completed

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Antonio	Jones

itoni	o Jones	1	St - For State	ate of Maryla	and / Depa	rtment of tificate of	Health a Death	and M	/lental	Hygi		J. No.	200	7	37	58	3 0
edic	Physicia al Examin	ın/	Registrar  1. Decedent's Name (First, Middl ANTONIO	JOI	NES				Date of Death Month November	Day V	'ear		e of Death 22 hrs	1			
,	<i>,</i>		4a. Facility Name (if not institution Harbor Hospital	n, give street and nu	umber)	4	b. City, Town Baltimore		ation of De			N/A	ty of Death				
	Funeral Director		5. Social Security Number 220-06-3394	6. Sex	7. Age (In yrs. Ia				f Under 24 Hours		OCT.7		Forei	thplace gn ountry)	(State or		
	ıny	L	Usual Residence of Decedent  10a. State  10b. County	44		Town or Locati									nside City		
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5	MID 6.16.1 3-10.30 2 should be filed within 72 hours after death with the Maryland h and would be filed within 72 hours after death with the Maryland 1.3 is marked other than "natural", or items 23a or 28a-f shr 27 is marked other than "natural", or items 23a or 28a-f shr imatic event, the Medical Examiner must be notified at once		2413 WILGRE	12. Was De	cedent Ever in U	.S. 13. Wa		1230	nic Origin?	? ( Spec	ify Yes or No-		ace - Ame	rican In	dian, Blac	k,	-
-	after death	by Funeral	3 Widowed 4 Di	Armed F  Armed F  Yes  Vorced If Yes, Give Yes  or Dates:	2 X No	1	Yes 2X	No s	pecify:			Speci		LAC			4
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	IMOFE, IMD Z-1Z-13-0030 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. The Triem 27 is marked other than or other traumatic event, the Medical		11TH  17. Father's Name (First, Middle PERNELL SC	<u> </u>	18.Mother's Name (First, Middle, Maiden Surnam GENINE JONES							me)					
3	Should be fi and Mental 7 is marked	To Be	19a. Informant's Name/Relation GENINE JONE	ship (Type, Print)		Mailing Address (Street and Number or Rural Route Number, City or Town, State 413 WILGREY CT. BALTO, MD. 21230						0					
	Ore, MIU ges I and 2 sho of Health and If item 27 is		20a. Method of Disposition  1 X Burial 2 Crematic		20b.	Place of Disporterematory or of EDAR H	sition (Name of ther place)	of ceme	tery,		Date . 29 , 2 (	20c. Locat	ion - City o	or Iown		MD	
:	Baltimore, MID A permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic		4 Donation 5 Other ignature of Funeral Service	e Licensee	/	22.	Name and Ad AT.VTN	dress of	f Facility SCR	RUGO	S FUN	IERAL	НОМ	E	212		
	Physician Medical	-	23a. Part I. Enter the disease, failure. List only one caus	O 1.							respiratory ar	est, shock, o	f heart		proximate etween Or Dea	nset and	
	aminer		Immediate Cause (Final diseas or condition resulting in death) Sequentially list conditions,			d alcohol and oxycodone intoxication consequence of):											4
_		Examiner	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	e c.	s a consequence									-			-
m	executed ian and ial - transit	dical Ex	X UNPENDED	d	PTT.27.28	-f porMF	C87/i 1	12/27	/O7 T								
	Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra	an/Med		23c. if ye 1 Liv	s, outcome of pre e birth	egnańcy 2 F	etal death	3	Ectopic		псу	23d. Da Mor	ate of deliventh	Day		Year	
	og å ≢å	Physician/Me	1 Yes 2 No 9 Part II. Other significant con	Jnknown g Un	egnant at time of one of the known ground to death but not		Other (Specification of the control		ven in Par	rt I.	23e. Did	tobacco use	contribute	to the	cause of c	leath?	_
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  The provided Head of the seculificate has been signed by lad in by the fineral director, nage 2 should be detacted.	d b									24a. Wa		24b. Were	autops		availal	ble
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	ital Recisions The scertificate page	Be	examiner?	Hospital:	Inpatient 2	✓ ER/Outpatie		-	of Death (		g Home 5	Residence	6 O	ther:			
	n of Vir nding Physia h. : After this	on: To	27 Manner of Death	(M	ate of Injury onth, Day, Year)	28b. Time o	of Injury 28		y at Work? es 2 X		28d. Describ unk						
	Division al or Attences after death al Director:	Certification:	2 Accident Ir 3 Suicide 6 X C 4 Homicide	t home, farm, st	farm, street, factory, office building, etc. 28f. Loc					28f. Location (Street and Number or Rural Route Number, City 1520 Hazel St. Baltimore, MD				Lity			
	Division of Vital Records.  To the Hospital or Attending Physician: The law requivithin 24 hours after death.  The filmental Director: After this certificate has been: The continued filled in by the filmeral director mace 2 should completely filled in by the filmeral director mace 2 should	Medical Ce		ath occurred at the time, date and place, and due to the cause(s) and mannestigation, in my opinion, death occurred at the time, date and place, an					, and dde	ner as stated. d due to the cause(s)							
4	To To	Me	29b Signature and title of ce	and mann	er stated.				e number			29d. Dat	te signed nber 23	(Month	Day,Yea	r)	
7	con 1	30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street							altimore	e, MD	21201						
1		Stat istra	e 31. Date filed (Month, Day, Y		Registrar's Sign	nature	antis										

State of Maryland / Department of Health and Mental Hygien 2007 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JOHN SON **Physician** CLARENCE /Medical 4a. Facility Name (If not institution, give street and number)

61N SECONAS HOJP37AU 4c. County of Death 4b. City, Town, or Location of Death **Examiner** EGGIGOM, DOSIDES N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | S. Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F 78 250-30-6983 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other traumatic event, If a Mulical Erantment. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Baltimore ty∑Yes 2 □ No N/A Director Maryland 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 21215 3809 Wabash Avenue #1B Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 3€ No Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TLALongshoreman 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luella Harley Clarence Johnson, Sr. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3809 Wabash Avenue #1BBaltimore, Md 21215 19a. Informant's Name/Relationship (Type, Print) Dorothy Johnson/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Woodlawn Cemetery 11/19/07 Woodlawn, Maryland 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): URINARY TRAUT INFECTION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à WLLEN DISEASE: 6.I. ALEEDING 1 Yes 2 No 3 Probably 4 Unknown WICER POST DEADENT SACRAL DECUBITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 28 No INSULIN DEFENDENT DIAMETES; HY PENTENSION 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 11 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Hospitel or Attending Pl 24 hours after death.Funerel Diractor: After th 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 124 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11/15/2017 mognibel, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STROET V GALTIMORE, MPEHBELL, MD JANET V 31. Date filed (Month, Day, Year)
NOV 2 7 2007 32 Registrar's Signature State Registrar

		-	For State Registrer	State of Marylan		artment of Heal			ne 007	37582
	Physicia		Decedent's Name (First, Middle, Las	0 /			2	Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4e. Facility Name (If not institution, give	street and number)	/	4b. City, Town, or Loca		16 /	4c. County of Deeth	1
	Funeral Director	4	212-78-0478	1	last birthday) Yrs.		Inder 24 Hrs. 8	Date of Birth (Month, Dey, Y	(eer) 9. Birth Cou	pplace (State or Foreign untry) MD
	faryland ahow		Usual Residence of Decedent  10a. State 10b. County		y, Town or Lo	cation				10d. Inside City Limits 1 No 2 No
	or 28s-1	Direct	MD n/a	Dal	timore	10f. Zip Code	<u> </u>	100	. Citizen of What Co	untry?
36	be filed within 72 hours after death with the Maryland stal Hyglene. sd other then "natural", or Items 23s or 28s-f show avent, the Medical Examinat must be notified at	by Funeral Director	3624 Bornview Avenue  11. Marital Status  12 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ Ñyo If Yes, Give Year or Dates:		21213 Was Decedent of Hispan f Yes, specify Cuban, Me	nic Origin? (Speci exican, Puerto Ri eccity:	ly Yes or No- can, etc.)	USA  14. Race - Amel Black, White Africa Specify:	
Maryland 21215-0036	within 72 hou ene. then *natura	Completed	15. Decedent's Ec (Specify only nighest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	(Give life.	dent's Usual Occupation kind of work done during DO NOT use retired) ter Specialist	g most of working		Sb. Kind of Business/I	
and 2	ould be filed a Mental Hygie arked other atic avent, to	Be	17. Father's Name (First, Middle, Last) James Carter		Canpai	18. 1	Mother's Name (			
lary	and and	은	19a. Informant's Name/Relationship		1	ng Address (Street and N	Number or Rural I	Route Number, (		lip Code)
Baltimore, N	permit. Peges 1 and 2 Department of Health Important: If Item 27 I any injury or other tra once.		Carolyn Jackson/ Moth  20a. Method of Disposition  1 (X)Burial 2 Cremation 3 C  4 Donation 5 Other (Specify	Removal from State	Place of Disponentery, created Memorial	Borniew Avenue sition (Name of matory or other place) Lal Park	11-24-0	7 W	oc. Location - City or occurrence occurrence of the contract o	
Balti	permit. Departm Importa any inju		21. Signatur of Funeral Service Licen	Miletla	92	2. Name and Address of 200 Liberty Rd.	., Randall	stown, MD	21133	Balto. Co.
8760,	The law requires thet the death certificate be executed  X  X  X  State has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai Examiner	23a Part 1. Enter the disease, or composition shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):	Lynpho		ospitatory union		Interval Between Onset and Death
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<u>α</u>	uires thet n signed by	þ	Part II. Other significant conditions of H I V				Part I.		acco use contribute to	
I Records,		Completed	Canda Equ	INES Syn	lran e			24a. Was an autopsy perform	ed2 death?	itopsy findings available completion of cause of 2 No
Vital	Physician: Tribis certifical	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	Other	Place of Death		) nce 6 ☐Other (Spe	cify)
Division of	Attending Phy in death.  • ctor: After this by the funeral c	Certification; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	of 28c, Injury at Work?  M 1 □ Yes	28 2	3d. Describe hov	v injury occurred	
Divis	F 6 F	Certific	3 Suicide 5 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, office	21	City or Town,	eet and Number or Ri State)	urai Houte Number,
	To the Hospitel of within 24 hours af To the Funeral D completely filled in	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicef Exer	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owtedge, dea ation and/or in	th occurred at the time, divestigation, in my opinio	late and place, ar in, death occurre	nd due to the car d at the time, da	use(s) and manner as te and place, and due	s stated.  to the cause(s)
)	To the within	M	29b. Signature and title of certifier	C. Buh	ny	29c. License nur 1000 -	58570	29	d. Date signed (Mont	th, Day, Year) - 18 2007
	10		30. Name and address of person who	L. Baker	MD	, Print)				
	Sta Regist		21 Date filed (Month -Day Most)	007 32 registrar's Sign	k A					

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

		Registrar			tificate of			Reg. No.		
Physicia /Medic		Decedent's Name (First, Middle, Later MARY)	LEWIS				2. Date of Do Month NOVEMB	Day	Year 2007	3. Time of Death
Examin		4a. Facility Name (If not institution, give HARBOR HOSP 5. Social Security Number 6. S	ITAL	last birthday)		LTIMOR	E B Date of Bi	rth	ounty of Death	place (State or Foreig
Director		241-32-6240 Usual Residence of Decedent	IDM 2€F 80	Yrs.	Months Days	Hours Min.	05/19	ay, Year)	Cour	ntry)
f ehow	ō	MD 10a. State 10b. County		ry, Town or Lo					1	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
or 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cour	ntry?
123a c		601 Cherrycres			212				S.A.	
year and expending the while results are obtain with the wayand the the should be also be shown the same of the same should be shown if it is a 27 is marked other then "natural", or items 23a or 28a-f shown or other traumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☆ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No II Yes, Give Year or Dates:		Vas Decedent of F f Yes, specify Cuba	dispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)	1	Specify: B1	etc.
natur	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Deced	lent's Usual Occup	pation during most of wo	rking	16b. Kind	d of Business/In	dustry
perint. Taysy a true should be lied white Deperment of Health and Mental Hygiene. Important: if Item 27 ie marked other then ' any injury or other traumatic event, the Ma pnce.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Maker	d)		Pri	vate	
Mental Hygien	Be	17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle	e, Maiden S	lumame)	
d Mer marke	၉	Daniel  19a. Informant's Name/Relationship (	Flood	19h Mailin	a Address /Street	Annie		fiel		Code)
alth ar 27 io	11	Nancyl.Watkins	** *		-	P1.#3		-		
Depertment important:		21. Signature of Funeral Service Licer	7 / 1	4		7.	naru r	ayro.	TT L	le MA uneral H
hysicie the bur	ed by Physician/Medical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect to dear one cause on each line.  BRAIN ST  Due to (or as a consect to conse	th. Do not entrice.  The Management of the Manag	O8 West er the mode of dyir HERNIA AR A UNCE	North  ng, such as cardian  FTION  CCIDEN  ONTROLLE	Ave Ba	ltime	Ore, MD	21201 Approximate Interval Between Onset and Death 3 DAYS 6 PAYS ery Day Year
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been signed by the attending physicien and should be detached for use as the burial-transit	To Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consect to the death one cause on each line.  BRAN ST  Due to (or as a consect to the death one cause on each line.  Due to (or as a consect to the death one cause on each line.  Due to (or as a consect to the death one consect to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death one contributing to death but not result to the death of the death one contribution to the death one contribution to the death one contribution to the death of the death one contribution to the death one contrib	th. Do not entread the property of the propert	West er the mode of dyir HERNIA A A NINCE DEctopic pregnancy Other (specify) Inderlying cause give t 3 DOA  28c. Injur Wor	NOTTH  Ing. such as cardian  FTION  CCIDEN  ONTROLLE  Ven in Part I.  26. Place of De.  Ter: 4   Nursing F	23e. Did  24a. Was autoperfit   Yes autoperfit   28d. Describe	tobacco us  Yes 2  s an opsy ormed? 2  No one) sidence 6 how injury	Ore, MD  3d. Date of delive Month  e contribute to to the second state of the second s	Approximate Interval Between Onset and Death S DAYS  DAYS  Part S DAYS
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View death.  Director: After this certificate has been signed by the atlending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit or in by the funeral director, page 2 should be detached for use as the burial-transit or in by the funeral director, page 2 should be detached for use as the burial-transit or in by the funeral director, page 2 should be detached for use as the burial-transit or in by the funeral director, page 2 should be detached for use as the burial-transit or in by the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	plications that aused the deat one cause on each line.  BRANST  Due to (or as a consect of the c	th. Do not entrice.  The Management of the Manag	D8 West er the mode of dyir HERNIA A A NINCE DEctopic pregnancy Other (specify)  anderlying cause give t 3 DOA  28c. Injury Wor M 1 Deet, factory, office	NOTTh  ng, such as cardian  FTION  CCIDEN  ONTROLLE  y  ren in Part I.  26. Place of De.  ner: 4   Nursing F  y at  k?  Yes 2   No	23e. Did  23e. Did  1	tobacco us  Yes 2  s an opsy ormed? 2  Sidence 6 how injury  (Street and own, State)  c cause(s) a date and g 29d. Date	ad. Date of delive Month  e contribute to to the Month  24b. Were autoprior to codeath? 1 Yes  Other (Special Occurred)  Number or Runal Manner as solace, and due to signed (Month,	Approximate Interval Between Onset and Death Shays  DAYS  PAYS  PA

			1_ For State	State of Maryl	land / Depa	artment of H	Health and M	Mental Hyg	iene	
			Ragistrar		Cei	rtificate of	Death	R	<sub>eg. N</sub> 2007	37585
	Physic /Medi		1. Decedent's Name (First, Middle, Last David R. Lee	<u></u>				2. Date of Deat Month November	Day Year 21,2007	3. Time of Death 6:54 A M
100	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of De	ath
			Lorien Nursing (			Bel	Air		Harford	
3	Funeral Director		217-14-4999	M and	yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 13, 1		inthplace (State or Foreign Country) ryland
	and *		Usual Residence of Decedent  10a. State 10b. County	100	: City, Town or Lo	cation				-
	Aaryli sho	5	MD Balti							10d. Inside City Limits 1 ☐ Yes 2 X No
	28a-	Director	10e. Street and Number	TIOLE	P	arkville		1	00 000000000000000000000000000000000000	
	Sa or		2906 Fifth Avenue				24		0g. Citizen of What C	ountry?
	death with the Maryland me 23a or 28a-f show Emitted be notified at	Funeral		12. Was Decedent Ever	in U.S.   13. \	212.		pecify Yes or No-	USA 14. Race - Am	encan Indian
ထ	or Ites	Fur	1 ☐ Never Married 2X Married	Armed Forces?	t		dispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wh	
8	rall, c	l by	3 Widowed 4 Divorced	1X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>X</b> No	Specify:		Specify: V	Vhite
2	2 should be tiled within 72 hours atter death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show aumatic event, if a Medical Evant ermun be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	lent's Usual Occup	nation during most of work	ana	16b. Kind of Busines	s/industry
2	of this	d L	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life. L	00 NOT use retired lectricia	d) -	B	ethlehem S	Steel
7	lled v her t		12 17. Father's Name (First, Middle, Last)		14.	TECCTICIO				
anc	ntal H	Be	James Herbert L	00				e (First, Middle, M		
Ž	should be and Mental I	2			401 14 11			e E. John		
Maryland 21215-0036	d 2 si th an 7 is r traur		19a. Informant's Name/Relationship (Ty Jean Lee-spouse	se, Print)					City or Town, State,	
a)	es 1 and 2 should to the alth and Ment fitem 27 is marked rother traumatic		20a. Method of Disposition	20	b. Place of Dispo-	sition (Name of			cyland 212	
Baltimore,	Pages nent of int: If It iry or o		1 XBurial 2 Cremation 3 P 4 Donation 5 Other (Specify)	emoval from State	cemetery, cren	natory or other place alley Mem	ce)		•	
	permit. Page Department of Important: If any injury of once.		21 Signature of Pyneral Service License			. Name and Addre	L.		Cimonium, M	
ñ	Dep Per		Hattor and	2010	EVA	INS FUNER	AL CHAPEI ON SERVI	, Dawler	Harford Ro Ville,MD 2	ad 1234
80,	4		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the c				440		Approximate
-37-	Physician		Immediate Cause (Final			,				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a con		AKDIA	L INFR	IKCTION	/	
	Examiner		Sequentially list conditions							
塔	D =	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	sequence of):					
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
/oC,	te be executed ysician and ie burial-transit	cal E	Tooling in Journ, 2000	Due to (or as a con-	sequence of):					
	physi physi the b									
XO	feath certificate attending phy. I for use as the	by Physician/Medi	IF FEMALE:	3c. If yes, outcome of pre	ignancy					
ă	atter atter	clar	in the past 12 months?	1 Live birth 2 □ F 4 □ Pregnant at time of	etat déath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
j.	the d ty the ached	Jysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	01 dduin 5 d	Ottlet (specify)				
	The law requires that the the has been signed by thoage 2 should be detached.	y P	Part II. Other significant conditions con	tributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribute!	to the cause of death?
cords	quire an sig uld blu	pa p	CORONARY ART	ERY DISFI	ASE ATRI	ALFIBR	RILLATION	; 1 ☐ Ye	s 2 □ No 3 🔀 P	robably 4 Dunknown
္သ	aw re	Completed	SEVERE CHRONI					24a. Was an		utopsy findings available
Ĕ	The I	E	DYSLIPI DEMIK				9/3(1/0)	autopsy	prior to death?	completion of cause of
	rdiffica	Be C	25. Was case referred to medical				26. Place of Deat	1  Yes 2 h (Check only one		s 2 No
>	hysic l direc	To	examiner? 1 ☐ Yes 2 🕱 No	ospital: 1   Inpatient 2	2 ☐ ER/Outpatient	3□ DOA Oth			nce 6 Other (Spe	ecify)
5	ng P		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c. Injun Work		28d. Describe ho		
2	eath.	cat	2 Accident investigation				Yes 2 □ No			
CIVISION	or At tter d lirect in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	it home, farm, stre ecify)	et, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	lural Route Number,
ם	prital nurs a eral C		200 Continue API Continue Photo							
	To the hospital or Attending Physician: The law requires that the death within 24 hours after death.  Within 24 hours after death.  With Euneral Director: Atten this certificate has been signed by the attent completely filled in by the funeral director, page 2 should be detached for a	edical	29a. Certifier Certifying Phys (Check only one) Medical Examir	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death unation and/or inv	occurred at the time estigation, in my or	ne, date and place, pinion, death occuri	and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	Vithin Fo the	Me	29b. Signature and title of certifier	, ,		29c. License	e number	29	d. Date signed (Mon	th, Day, Year)
	7		Midle	Repu p	11)	74	5344		2 1	
Á	1	-		4	Item 23a) (Type. F					007
L	11		SURESH DHAT	moleted cause of death (I	1 622	S. UNIO	N AVE	HAVRE D	EGRACE F	1021078
	Sta		31. Date filed (Month, Day, Year)	327 Registrar's Si	gnature	AP 8	/	.,		
14	Registra	ar	NOV 2 7 200	1 Blenson	A. LADO					

Le 11-21-07 654

			For 1 _ State	State of Ma	-	partment of I		ental Hygi	ene	
	_		Registrar			ertificate of	Death		g. No.2 0 0 7	37586
10.	Physicia	an	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
	/Medic	_	4a. Facility Name (If not institution, give			4h City Town	or Location of Death	Nov. 2	24 , 2007 4c. County of Deat	3:27P.™
)	Examin	er			raina C		arkville		Baltim	
-	Funeral		Genesis Cro		e (In yrs. last birtho	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birt	hplace (State or Foreign
	Director		214-01-5934	1 <b>∑</b> M 2□F	89 Yrs	Months Days	Hours Min.	(Month, Day,	,1918 Ma	ryland
	p .		Usual Residence of Decedent					may 10	7.7.7.10	-
	arylar show d at	_	10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits 1 ☐ Yes XXNo
	ne Ma 8a-f s	cto	MD Balti	more			Parkvil.			
	/ith the or 2 be no	Director	10e. Street and Number			10f, Zip Code		10	g. Citizen of What Co	
	s 23e	Funeral	8505 Dempster				234	sifu Vee or No	US 14. Race - Ame	
	er de Item	in.	11. Marital Status	12. Was Decedent B		<ol> <li>Was Decedent of I If Yes, specify Cub</li> </ol>	oan, Mexican, Puerto	Rican, etc.)	Black, White	
36	rs aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 √Yes 2 1 N If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	white
21215-0036	2 hou atura cal E	ed	15. Decedent's E		16a. D	ecedent's Usual Occu	pation	11	   6b. Kind of Business/	Industry
7	hin 72 In "n Medi	ple	(Specify only highest gr Elementary/Secondary (0-12)	rade completed) College (1-4or 5		Give kind of work done fe. DO NOT use retire	e during most of worki ed)	ng		
2	d with grene er tha	Completed	12			ble Seale	er	w	estern E	lectric
g	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Name	(First, Middle, M	faiden Surname)	
<u> a</u>	should band Ment s marked umatic e	2	George Lewe	etzki			Theresa	a Krone	r	
Maryland	2 sho		19a. Informant's Name/Relationship	(Type. Print)		•			City or Town, State, 2	
	and lealth m 27 her tr		Kathryn Lewetz	<u>:ki - wif</u>		05 Dempsi			Baltimor 20c. Location - City or	e,MD 21234
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 [		cemetery,	crematory or other pla		vale 2	coc. Location - City of	Town, State
Ħ	t. Pa tmen tant; ijury		4☐Donation 5 ☐ Other (Special		Parkw	ood Cemet	tery 11/	28/07	Baltimor	e, MD
Bal	permit. Departr Importa any Inju		21. Signature of Funeral Service	Miller				Balt	imore. M	D 21234
			23a Parti Enter the disease or cor	mulications that caused	the dieth. Do not	Evans Fur	neral Cha	apel &	imore, M Crematio	n Srvcs Approximate
			23a. Parti. Enter the disease, or/cor shock, or heart failure. List only Immediate Cause (Final		e.	enter the mode of dy	ing, such as cardiac c	or respiratory arre	iot,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ASCUO						yours
	Examiner			Due to (or as	a consequence of)					10.00
4	#1	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	D	a consequence of)					9+023
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
Ó	exec an and rial-tra	Еха	resulting in death) Last	Due to (or as	a consequence of)					-
8760,	icate be executed physician and s the burial-transit	dical		d						
9	rtifica ng ph as th	/edi	IS SENALE.							
ŏ	th cel	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		3 □Ectopic pregnanc	cv		23d. Date of de	,
P.O. Box	e dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4∐Pregnant at 9∐Unknown		5 ☐ Other (specify)			Month	Day Year
<u>Ч</u>	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Completed by Physician/Me	9 Unknown				iven in Deut I	02a Did tah	acco use contribute to	a the cause of death?
ŝ	res th	by	Part II. Other significant conditions	contributing to death bi	_		<b>,</b>	23e. Did t0b		robably 4 Unknown
Orc	requi	ted	シット		1 project	living anen	~~~			- Lenkinowii
ec Sec	e 2 sl	nple	Renal insufficien	<del>"``</del>				24a. Was ar autopsy perform	y prior to	utopsy findings available completion of cause of
Division or Vital Records,	cate pag	Ç	hypothypoid						No 1 ☐ Yes	2 □ No
<u> </u>	iclan certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		Ot	26. Place of Death			
ō	Phys this ral dir	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Outpo	THEIR 3 DOX	4 A Nursing Ho		nce 6 Other (Spe w injury occurred	ecify)
on	ding h. After fune	ion	1 X Natural 5 ☐ Pending	(Month, Day		iry Wo	ork? □Yes 2□No	200, 20001120 110	w injury doddinad	
S	Attending Physician: r death. ector: After this certifica by the funeral director, I	fica	3 Suicide 6 Could not I	be 28e. Place of inju		, street, factory, office			reet and Number or R	ural Route Number,
	after after 1 Dire	Certification:	4 ☐ Homicide determined	building, et	c. (Specity)		l.	City or Town	, State)	
	ospita hours inera y fille			Physician: To the best						
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical	(Check only 2 ☐ Medical Exa	aminer: On the basis o and manner sta		or investigation, in my	opinion, death occur	red at the time, da	ate and place, and du	e to the cause(s)
	To t To tl	Ž	29b. Signature and title of certifier			29c. Licen	ise number	29	9d. Date signed (Mon	th, Day, Year)
)	~		Wind Klus	'X'		D	31795		11/20/07	
i	1+1		<ol><li>Name and address of person who</li></ol>	o completed cause of d					4 *	
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	Sta Registr		Wend Klosz n ; 31. Date filed (Month, Day, Year) NOV 2 7 20	107 Andrews	and digitature	selle!				
	-		1404 2 2	2						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2007 рм George Earl Laucht 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Oak Crest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 217–03–8127 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days 09/27/1918 Hours 1 X M 2 □ F 89 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at MD Baltimore 1 TYes 2 No Funeral Director Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or mortant: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be none. 8832 Walther Blvd. 21234 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Meat Supervisor Acme Markets 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Laucht Elizabeth Schaeffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan K. Aune, Daughter 328 Timberton Circle, Bellefonte, PA 16823 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 11/27/2007 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Ulapandna ? 5305 Harford Rd. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any conditions, it immediates cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a consequence of The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical SS IF FEMALE; for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 W 10 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred I or Attending F after death. 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 8800 Walth 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

07-09013	Please Typ	e or Print in B	lack Indelible	ink. Ensure	e All Copie	s Are Legil	ole.			
Frederick G Latreille	St. - For State	ate of Maryland	/ Department of Certificate of		d Mental Hy	rgiene Reg.	No. 200	17 3758		
Physician/	Registrar 1. Decedent's Name (First, Middl	e,Last)				2. Date of Death		3. Time of Death 0614 hrs		
Medical Examiner	Frederic	k G. Latrei	lle, Jr.	4b City Town or	Location of Death	Month D. November 2:	2, 2007 4c. County of Death			
	4a. Facility Name (if not institution Shady Grove Adventise)		)	Rockville	2000001101200		Montgomery			
Funeral	5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year		8. Date of Birth(	MM/DD/YYYY) 9. Bir Foreig	an i		
Director	216-64-0787	1 X M 2 F	56 Y	rs. Mortus Day	S TIOUIS IVIII.	September	21, 1951 <sup>co</sup>	untry) Maryland		
any	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Loc	ation				10d. Inside City Limits		
<u> </u>		ntgomery		Ga	ithersbu	cg		1 X Yes 2 No		
the Maryland to 28a-f sheiffied at once	10e. Street and Number	regomer,		10f. Zip Code		10g	. Citizen of What Cou	ntry?		
eath with the Maryland items 23n or 28a-f show ust be notified at once.	390 North Sun	nmit Avenue	#002	Vas Decedent of Hi	20877	pecify Yes or No-		States ican Indian, Black,		
r death with , or items 23 r must be no	<ul><li>11. Marital Status</li><li>1 Never Married 2 N</li></ul>	12. Was Deceder		Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	White, etc.			
fter death		vorced If Yes, Give Year or Dates:	1	Yes 2 X No				White		
nours afte	15. Decedent's Education (Spe	ecify only highest grade co	during	ent's Usual Occupa most of working life	ation (Give kind of version of the contract of		6b. Kind of Business	Industry		
36 nin 72 h than ", dical P	Elementary/Secondary (0-12)	College (1-4 o		ychiatri	c Aide		Mental B	Health		
5-0036 lited within 72 hours Hygiene 1 other than "natu the Medical Exam Completed	17. Father's Name (First, Middle			y childri	18.Mother's Name	e (First, Middle, Ma	aiden Surname)	0.195		
Pe first	Fred e	erick G. Lat	reille, Sr.	ling Address (Stre	eet and Number or	Grace Luc Rural Route Numb	ille Fishe er, City or Town, Stat	e, Zip Code)		
ID 21; should be and Mer in artic ew	Grace F. Lati		4			Rockvi1	le,Maryla	nd 20852		
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumant	20a. Method of Disposition		20b. Place of Dis	osition (Name of co	emetery,	Date	20c. Location - City of	r Town, State		
mor Pages ent of unt: If	Burial 2 X Crematic	on 3 Removal from	Mont	gomery	No. 25	vember 2007	Bethesd	a. Maryland		
Salti ermit. epartm nports ijury o	21. Signature of Funeral Service	e Licensee	2	Rockvil.	ss of Facility KOI le,Inc.	300 West	Montgome:	uneral Home/ ry Avenue		
Physician	23a. Part I. Enter the disease,	or complications that caus	M00335 ded the death. Do not ent	Rockvil er the mode of dying	le, Mary g, such as cardiac	and 2083 or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and		
'Medical	failure. List only one caus	e on each line.	es and smoke inha					Death		
caminer	or condition resulting in death)	Due to (or as a co								
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urted nd ransit	events resulting in death) Last	d								
be execution a unial - adica	UNPENDED	AMENDED					23d. Date of delive			
Division of Vital Records, P.O. Box 68760, 10xpital or Attending Physician: The law requires that the death certificate be executed the hours after death. Funeral Director: After this certificate has been signed by the attending physician and lety filled in by the funeral director, page 2 should be detached for use as the burial - transial Certification: To Be Completed by Physician/Medical E)	IF FEMALE: 23b. Was decedent pregnant in		come of pregnancy	Fetal death	3 Ectopic pregi	nancy	Month	Day Year		
ox 61 th cert uttendir or use a	past 12 months?	lelie e un	t at time of death 5	Other (Specify)						
b. Bc the degraph the soy the so	Part II. Other significant cond	9 Olikilowi	eath but not resulting in	he underlying caus	e given in Part I.			to the cause of death?		
P.O. es that the signed by be detach						-		robably 4 Unknown		
Records, The law requires ficate has been signage 2 should bb Completed						24a. Was a autop: perfor	sy prior t	autopsy findings available o completion of cause of		
Reco The law cate has page 2 s				_		1 Yes		Yes 2 No		
Vital Recysician: The ysician: The his certificate director, page	25. Was case referred to medi examiner?				Other		Residence 6 Ot	her:		
of Viting Physic After this uneral direction.	1 V Yes 2 No	28a, Date of	atient 2 ✓ ER/Outpa Injury 28b. Time		njury at Work?	28d. Describe h	now injury occurred	-		
Division of Vital Records, spital or Attending Physician: The law require tours after death.  neral Director: After this certificate has been sinfilled in by the funeral director, page 2 should be Certification: To Be Completed	1 Natural 5 Pe	ending Nov 22, 20	0621 hr	5 1	Yes 2 V No	1	red in house fire			
visic or Atte fler der Directo in by t	2 V Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State)									
Divisior Hospital or Attend 44 hours after death Funeral Director: tely filled in by the										
Division  To the Hospital or Attends within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification	(Check only 1 Certifying one) 2 Medical E	xaminer: On the basis of	examination and/or inve	stigation, in my opir	nion, death occurre	d at the time, date	and place, and due to	the cause(s)		
To To To To Com	29b. Signature and title of cer	and mariner sta	1	29c. Lic	ense number		29d. Date signed (	Month, Day, Year)		
	Calres	1	1	О.	C.M.E.		November 23,			
17	30. Name and address of personal Zabiullah Ali, M.D.	son who completed cause Assistant Medica	of death (tem 23a)  Examiner 111	Penn Street, B	altimore, MD :	21201				
	2abiulian All, IVI.D.  31. Date filed (Month, Day, Ye		strar's Signature		<del></del>					

7-08					oe or Print i								le.	
Michael Allen Lewallen State of Maryland / Department of Health  1- For State Certificate of Death  Registrar  1. Decedent's Name (First, Middle, Last)								d Menta	al Hygiene		200	7 3758		
			Registrar	o (First Midd	In Last)		Jertifica	te of De	eatri		2. Date o	Reg. No	0.	3. Time of Death
Medi	Physicia ical Examiı		Michael		Lewallen						Month Nover	nber 17,	Year 2007	0925 hrs
7					on, give street and n	umber)		4b. C	City, Town, or	r Location of		-	4c. County of Death	
روي		н	16505 Baec	derwood <del>T</del>	errace Lane	9		D	erwood				Montgomery	
	Funeral		5. Social Security N		6. Sex	7. Age (In y	yrs. last birth	· · · ·	Under 1 Yea				M/DD/YYYY) 9. Bir Foreig	n
	Director		215-76-6	5675	1 X M 2 F	4	-1	Yrs.	nontins Day	110013	Dec.	3, 1	L965 co	untry) Maryland
	ý	F	Usual Residence of 10a. State	f Decedent 10b. County		100	City, Town	or Location						10d. Inside City Limits
	- ow a		Maryland	,	omery	100.	Derv							1 Yes 2 X No
	rylanc a-f sh	용	10e. Street and Nu						f. Zip Code			10g. C	Citizen of What Cou	ntry?
	he Ma or 28	Director	16505 I	Baeder	wood Lane				2085	5			United :	States
=	with the 18 23a is 23a		11. Marital Status		12. Was De	cedent Ever	in U.S.				n? ( Specify Yes			can Indian, Black,
5	death r iten	Funeral	1 Never Marri	ed 2 X M	larried Armed	77	No	If Yes,	specify Cuba	n, Mexican, i	Puerto Rican, et	0.)	White, etc.	
	after	by	3 Widowed		vorced If Yes, Give Ye or Dates:				s 2 X No			1.5		nite
	hours natur Exam	핑			ecify only highest gra					ation (Give ki e. DO <b>NOT</b> u	ind of work done ise retired)	1160	o. Kind of Business/	Industry
	36 iin 72 shan t	plet	Elementary/Sec	ondary (U-12)	College 4	(1-4 or 5+)	S	enior	Syste	ms Eng	ineer	Go	vernment	Contracting
	d with	Completed	17. Father's Name	(First, Middle	·				B) TT		Name (First, Mi			
	215 be file stal He ked o	Be			ver Lewal	1en				Joar	n Alaine	Lawl	norne	
	MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	은	19a. Informant's Na					-					City or Town, State	
	MC Id 2 st alth an m 27 i				allen/Wif						Jane, De		d, Maryla:	
	of He		20a. Method of Dis		n 3 Removal			ory or other	n (Name of co place)	emetery,	Novemb	or	ŕ	
	Page ment fant: or of			Other S			Montgo		remator		24. 20	<u> </u>		Maryland
	Baltimore, MD 21215-0036  permit. Pages I and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If titen 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	uneral Service	Licensee	. 1	101173	Rober	t A. Pu	mphrey	Funeral 1	Home,	Rockville,	Inc.
	Physician		23a. Part I. Enter t	he disease, o	r complications hat			t enter the n	node of dying	gomery A	rdiac or respirat	ockv11 ory arrest,	le, Marylar	Approximate Interval
~	Medical		failure. List or	nly one cause	e on eac <del>h line.</del> /									Between Onset and Death
~	Examiner		Immediate Cause or condition result		e a. <u>Dilate</u> Due to (or as			LIV						
		L	Sequentially list co		b		- ^							
		ine	if any, leading to it cause. Enter Und	erlying Cause	Due to (or as	a conseque	nce of):							1
	/ P #	Examiner	(Disease or injury events resulting in		Due to (or as	a conseque	nce of):							
P	recuted	alE			d									
	a a e	Physician/Medic	X UNPENDED		X AMENDER	rMF. 987	4, 12/	5/07_TT	/ #23a	.27.perl	Æ.g874.	12/24/(	)7 TT 23d. Date of deliver	
	68760, certificate be nding physici se as the buri	N/	IF FEMALE: 23b. Was deceden		the c	, outcome of birth		Fetal	death 3	Ectopic	pregnancy			y Day Year
	th cert	icia	past 12 month			gnant at time	of		(Specify)					
	Bo he dea the a hed fo	hys	1 Yes 2		9 Unk	nown		- 1- 4		niven in Da	et l 230	Did tobac	co use contribute to	the cause of death?
	Division of Vital Records, P.O. Box 68760, fat or Attending Physician: The law requires that the death certificate be extra star death.  The Director: After this certificate has been signed by the attending physician led in by the funeral director, page 2 should be detached for use as the burial	by F	Part II. Other sign	nncant cond	itions contributing	to death but	not resultin	g in the uno	enying cause	given in Fai		_		bably 4 Unknown
	duires quires en sig uld be								· · ·		1 24a	. Was an		utopsy findings available
	cords law requi has been 2 should	Completed	-								—   <u> </u>	autopsy performe	d? death?	completion of cause of
	tal Rec riant The l certificate bector, page	S									Lain.	Yes 2	No 1 🗸	'es 2 No
	Vital   ysician; his certif director,	Be	25. Was case refe examiner?	erred to medic	Hospital:	Inpatient	2 EB/O	outpatient 3		Other	Check only one Nursing Home	5 Res	sidence 6 🗸 Oth	er: Scene
	of Vi Physic ter this eral dir	₽.	1 Yes 27. Manner of Dea	2 No	28a. Da	te of Injury		Time of Inju		jury at Work			injury occurred	
	ion of tending Phreath.  to After the funeral	ion	1 X Natural		nding (Mo	nth, Day,Year)			1	Yes 2	No			
	ivision or Attendafter death Director:	Certification:	2 Accident 3 Suicide		estigation 28e. Pl	ace of Injury	- At home, f	arm, street, 1	factory, office	building, etc				tural Route Number, City
	Division or At ours after dours after diffiled in by	erti	4 Homicide		ermined (Specia	(y)					Or	own, State	=) 	
	Hos 24 h Fun tely		29a. Certifier 1		Physician: To the b	est of my kn	owledge, de	ath occurred	at the time,	date and pla	ice, and due to the	ne cause(s	) and manner as sta	ited.
	To the How within 24 h To the Fur	Medical	2 V	J	aminer:On the bas and manne		uon and/or	investigation		nse number	curred at the tim		9d. Date signed (M	
	N. A	Σ	29b. Signature an	u title of certif		1				ose number			November 18, 2	
<b>T</b>	Brit-		( ) b	ul	reell	<u> </u>	(lto 00-1							
(	1 pp		30. Name and add		on who completed co Assistant Medi			1 Penn S	treet, Bal	timore, M	D 21201			
		tate	31. Date filed (Mo.	nth, Day, Yea		45.		Soul			****		<u> </u>	
	Regis			NOV S	7 2007	Registrar's S	15	NO BAR	C. P					

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** LOLA MARIE LONG 1:50 PM VON 24, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL CARROLL HOSPICE DOVE HOUSE 8. Date of Birth (Month, Day, Year) 12/19/1909 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 □ F 213-05-1356 97 Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 XYes 2 No Director CARROLL MANCHESTER MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be n once. 21102 3316 WILHELM LANE USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Specify: Completed by Specify: WHITE 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER MANUFACTURING 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERBERT WASHINGTON DANNER LOLA EDITH BRUMMEL 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DOROTHY RUPP 3393 YORK ST., MANCHESTER, MD 21102 SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHILOH CEMETERY 11/27/07 HAMPSTEAD, MD 5 Other (Specify) eral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Sinnature 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner H.F Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cous. (Course of July) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 XNo 2 **X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE ဥ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the it 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

mound

M. PANSURIYA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

349

32. gistrar's Signature

DHMH 17 Rev 1/2001

malalm

29c. License number

Doc 51705

29d. Date signed (Month, Day, Year)

DR, Hestminster, MD21157

11-26-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ам Laurence Ann Lehnen 25, 2007 8:30 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilcrest Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🗓 F 100 357-24-6336 Yrs Ohio Director June 25, 1907 Usual Residence of Decedent a or 28a-f show be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Director MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4501 K. Dunton Terrace 21128 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White ð 3 X Widowed 4 ☐ Divorced the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George L. Lemaire Marie Louise Mayer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Method of Disposition

| Date | Control Date | Cont C. Geraldine Worthington/Daughtler Pages 1 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 060 **Physician** months /Medical Due to (or as a consequence of): Examiner pharqueal dysphasia VO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ernentia Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending 1 Natural Injury I hours after death.

uneral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) To use within 24 hours are. To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 25/07 o Vital

Maryland 21215-0036

Division

Year, 31. Date filed (Month. Day.

29a, Certifier

one)

(Check only

29b. Signature and atle of dertifier

UW)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (ferr) 23a) (Type, Print) & BMC 6701

N. Charles St.

Registrar

2007

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 0 37592 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Mason 8:25 PM Andrew NOV 2007 22 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Examiner County General Hospital Howard. Howard Co (umbia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last b rthday) 8. Date of Birth (Month, Day, (State or Foreign **Funeral** Months Days 064-12-1885 12-5-1920 VA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits r 28a-f sho notified a 1 X Yes 2 □ No Director HOWARD COLUMBIA 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? "natural", or items 23a or 11250-A CRYSTAL RUN 21044 USA Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 Divorced BLACK. Completed er than "natur t, the Men al 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR CEDAR 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be GRACIE MAE WILSON P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA PEARSON/DAUGHTER 5751 BOYDTON PLANK RD. BRODNAX, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State important: if it any injury or o 1 Normal 2 □ Cremation 3 Removal from State GREEN'S CHAPEL CH.CEM 11-29-07 BRODNAX, VA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signatura of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD 21217 ames wition Approximate Interval Between Onset and Death 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Fibrosis 109ms /Medical Due to (or as a consequent of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed sician and buriai-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ right pneumothorax 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 1□ Yes 2□ No 2 KM or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 100 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 042892 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patuxent Parkway Columbia Francis Muidian 4:416 10724 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

			For State	State	of Marylan		artmer			and M	•			0.7	07500
		4	Registrar  1. Decedent's Name (First, Middle	e, Last)			timoda				2. Date of De		<u>~ZU</u>	$\cup$	3. Time of Death
	Physicia		Helen	F.	Mar	tino				N(	DVEMBE	ER B	23.	Year ZWZ17	02:11FM
	/Medio Examin		4a. Facility Name (If not institution		ımber)	nter	4b. City	, Town, or	Location o	of Death	on	40	c. County		imore
in a	is response southerns .		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Bir	th		9 Birthol	ace (State or Foreign
	Funeral Director		219-32-5893	1□ M 2\ F		71 Yrs.	Months	Days	Hours	Min.	(Month, Da January	ıy, Year		Count	try) ` _
			Usual Residence of Decedent		,						bartary	15,	1550	ran y	Idila
	ylanc now at		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside City Limits
	a-f sl	ctor	Maryland Balt	imore		Towson	i								1 ☐ Yes 2 No
	or 28 e not	Director	10e. Street and Number				10f. Zi	p Code				10g. Ci	itizen of W	Vhat Count	try?
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	r dea	Funeral	11. Marital Status	Armed F		.S. 13.	Was Dece If Yes, spe	dent of Hi	spanic Ori n, Mexicar	gin? (Spe	cify Yes or No Rican, etc.)	)-		e - America k, White, e	
0	s afte ; or it amin	by Fi	1 Never Married 2 Marr	If Yes, G	2 <b>⊠</b> No ive		1 ☐ Yes	2 <b>X</b> No	Specify:				Specify	Whi	ite
2	hours tural' al Ex		3 Widowed 4 Divorced	Year or I	Dates:	16a. Dece	dent'e Hei	ial Occup	ation			16h k	Kind of Bu	siness/Ind	uetr/
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7	withi iene. thar the M	шc	Elementary/Secondary (0-12) 12 years	College	(1-4or 5+)	Admir						St	teel		
2	i filed I Hyg other ent, i	Be C	17. Father's Name (First, Middle,	Last)		1 1001121					(First, Middle			ie)	
Ö	lid be lental <b>ked</b> ic ev	To B	Martin T. Veyst	rk					Frai	nces	T. Lip	ka			
ב ב	should be should	_	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Addres	s (Street a	and Numbe	er or Rura	l Route Numb	er, City	or Town,	State, Zip	Code)
Ž	and 2 aalth a 1 27 to er tra		Marlene Peters	sist	ter	9 Gou	cher	Wood	ls Co	urt,	Towson	, Ma	aryla	ind 2	21286
5	es 1 a of He item		20a. Method of Disposition	2 Domouni from		Place of Dispo cemetery, crea	matory or	other plac	e)   N	ovem]	ate ber	20c. L	_ocation -	City or Tov	wn, State
ĺ	Page nent ant: It		4 Donation 5 Dother (S		Sac	red Hear	t of J	Jesus (	Cem.	27,		Dun	ndalk	, Mar	yland
משב	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If tiem 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	moll		Name a Onne	nd Addres	s of Facili	al Ho	me Of Road,	Dunc	dalk,	P.A.	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	th. Do not ent	er the mo	de of dyin	g, such as	cardiac o	r respiratory a	rrest,	<i><b>34,11</b></i>		Approximate Interval Between
j.	Physician		Immediate Cause (Final disease or condition		_TI-OR										Onset and Death
	/Medical		resulting in death)	a	(or as a conseq										
	Examiner		Constitution and distance	SEI	PSIS										
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a conseq										
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	ALL BOU		BSTR	UCTI	ON						
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0	cate b	dical		d										_	
ر د د	certifi ding se as	Physician/Me	IF FEMALE:	23c. If ves. or	utcome pf pregna	ancv							ood Dot	e of delive	n/
ב	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2  Feta	aldeath 3	∃Ectopic p ∃ Other <i>(s</i>						Moi		Day Year
;	the d y the ched	ıysi	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□Unki											
	that led by deta		Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying	cause give	en in Part I		23e. Did t	tobacco	use contr	ribute to th	e cause of death?
2	quires n sign ald be	d by									1 🗆	Yes 2	2 No	3 ☐ Proba	ably 4 □Unknown
3	aw rec	lete									24a. Was		24b. \	Were autop	osy findings available
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ğ	an: 'antifica tor, p	Be	25. Was case referred to medica						26. Place	of Death	1 Yes (Check only o	2 <b>X.</b> N one)	10 1	1 1 1 63	215010
>	nysici iis cei direc	To B	examiner? 1 Yes 2 No	Hospital: 1	Unpatient 2 □	] ER/Outpatier	nt 3 D	OA Othe	er: 4□ Nu	ursing Hon	ne 5∐Resi	dence	6 □Oth	er (Specify	()
	ing Pt (fter t† Ineral		27. Manner of Death 1 Natural 5 ☐ Pendin		e of Injury nth, Day Year)	28b. Time o Injury		28c. Injury Work	(?		28d. Describe	how inju	ury occurr	ed	
2	tendi eath. tor: A the fu	cati	2 Accident investig	gation			M		Yes 2 □						
2	or At after d Direct In by	Certification:	4 ☐ Homicide determ	inca   200. Flat	e of injury - At he ding, etc. (Special	ome, farm, sti	eet, factoi	ry, office		2	28f. Location ( City or To	Street a wn, Sta	and Numb te)	er or Rurai	l Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical	ig Physician: To the	e best of my kno basis of examina	owledge, deat	h occurred	d at the tin	ne, date ar	nd place, a	and due to the	cause(	s) and ma	anner as sta	ated.
	thin 2, the I	Medical	one) 29b. Signature and title of certifie	1	nner stated.		20	c. License	number			294 D	ate elanea	d (Month, I	Day Year)
	7.¥ ₹ 8	The same of	235. Signature and title of certifie	12.	1		-		284			_0u. D	11/2	XX	
	1		20 Name of addition	ubo complaind	Ina hi dansh /lu	n 220\ (T-==	Drin*)	7%II	terre San? "F					4/10-	<i>T</i>
X			30. Name and address of person MARK HARRY	Who completed call FRAIMAN		7601.		ER T	RTUE	- T(	owson.	MOI	RYLA	ND P	1204
	Sta	te	31. Date filed (Month, Day, Year)	32	Registrar's Signa	ature	cate 9	none ( % deal	7 t at Y la	R	na v v tur turk t 19 i	1 101	· > 1 hm 17	t about Barre	
	Registr		MOV 2 7	2007	Addres J.	S. September	and the same								

			1 _ For State	State of Maryland /	Department of Health and N	Mental Hygie	ene 7	37594
			* Hegistrar		Certificate of Death		No. UUI	
	Physici	an	Decedent's Name (First, Middle, Last)		- 0	Date of Death     Month	Day Year	3. Time of Death
	/Media	al	Julia 1	7. MOO		NOVEMBER	23 2007	1:21 P M
	Examir	er	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death	
			ATLANTIC GENERAL I  5. Social Security Number 6. Sex		BERLIN  rthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	WORCEST	
	Funeral Director			IM 201 97	Yrs. Months Days Hours Min.	(Month, Day, Y		nplace (State or Foreign
		}	Usual Residence of Decedent			12/31/19	111 1110	irylana
	nylan how		10a. State 10b. County	10c. City, Tov	n or Location			10d. Inside City Limits
	Ma-f-e	cto	Mc Worce	ster T	Berlin			1 ☐ Yes 2 €No
	ith th	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	untry?
	ath w	rai	9715 Healthw	ay Drive	21811		USA	
	er de	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	rican Indian, e. etc.
36	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Itema 23a or 28a-f ehow ent. I'm Medical Examir an inset be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐ Yes 2 Mood. If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify:	01:1
Ş	ture tal E	ed	15 Decedent's Edu	cation 16a	. Decedent's Usual Occupation	16	b. Kind of Business/l	MITE
215	nin 77	Completed	(Specify only highest grade	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing		
21,	d with	E	Contain (0-12)	Conege (1-40: 3+)	Home maker		own ho	me
ב	oth Vent.	Bec	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		
<u>a</u>	should be nd Mental marked o	To E	Carlton M	1º Cormick	Ann	a Zek	oiline	
a	2 shc and and le m		19a. Informant's Name/Relationship (Ty)	oe, Print) 198	o. Mailing Address (Street and Number or Run	al Route Number, C	ity or Town, State, Z.	ip Code)
2	and ealth m 27		Carol Poetzel-	daughter 4	ab Symphony Circl	e#343	Hunt Valle	Md21030
o.	ges 1 t of 1 if ite or ot		20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ R	emoval from State	ry, crematory or other place)	1	c. Location - City or T	own, State
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or iteme 23a or 28a-1 ehow eny injury or other traumatic event. If a Madical Examinat must be notified at once.		4 □ Donation 5 □ Other (Specify)	Ce	metery	6/2007	Unite Mars	sh, Md
Bal	Depar mpou		21. Signature of Funeral Service License		22. Name and Address of Facility Evound Funeral Ch 8800 Harford Road	apel + Cren	nation Sv	rs-Parkville
			232 Part 1 Enter the disease or compli	A V (autu	18800 Harford Road	Parkuille	md 212	-34 Approximate
			shock, or heart failure. List only on Immediate Cause (Final	20 1 1	not enter the mode of dying, such as cardiac		•	Interval Between Opset and Death
	Physician /Medical		disease or condition resulting in death)		adiovasular Doses	de (		Cears
	Examiner			Due to (or as a consequence	of):			
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):			
25	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
7	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as a consequence	of):			
/3//'3 /02 <b>68760</b> ,	ficate be executed physician and is the burial-transi	edical	C a					
- /	75 70 -4	Med	IF FEMALE:					
50 / 1/2 Box	death certii e attending d for use a	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	
) O	0 0 U	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)		Month	Day Year
AQ.	that the ded by the	P	Part II. Other significant conditions con	tributing to doub but not reculting	The underhing seven man in Red (	23a Did tahar	co use contribute to	the source of death?
ecords,	8 P 9	1 by	(, )	_	in the underlying cause given are are.		2 □ No 3 □ Pro	
S O	w requir been s should	ete	Unhan	rat Tufecto	( <sub>m</sub> -			
Moor A	The lav	Completed	- Whay	rad suffects	<u> </u>	24a. Was an autopsy performe	24b. Were aut prior to o d? death?	opsy findings available ompletion of cause of
3 7 Z		ပိ	25. Was case referred to medical			1□ Yes 26		2□ No
ે જે ≥	Ger Ger	0 8	examiner?	ospital: 1 XInpatient 2 ☐ ER/O	Other	h Check only one	a E 011 / 12	
800	ding Phys	-	27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at	28d. Describe how	e 6 Other (Specinjury occurred	ועזו)
ુ <b>ં</b>		atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury Work? M 1 ☐ Yes 2 ☐ No			
2002 ivision	or Attend effer death Director:	ILLIC	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa	arm, street, factory, office	28f. Location (Stree City or Town, S	at and Number or Rui	ral Route Number,
13660	tal or rs efte al Dir	Certification:		building, etc. (Specify)		City of TOWN, S	olate)	
1	To the Hospital or Avilyin 24 hours effer to the Funeral Direction plately filled in by	edicai	(Check only 2 Medical Examin	ician: To the best of my knowledger: On the basis of examination ar	e, death occurred at the time, date and place, ad/or investigation, in my opinion, death occur	and due to the caus	e(s) and manner as	stated.
	the the mplet	Med	Unitely	and manner stated.				
	o T with		29b. Signature and title of certifier	7	29c. License number	290.	Date signed (Month	, Day, 19ar)
	0		1/ Meller		1008/61		11 1210	(
	3		WWW slare and address of person who col	impleted cause of death (Item 23a)	Talwa Fauret	Island,	Dr 199	44
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Angelle &	- Thank	111	<i>v</i>
	Registr		NOV 2 7 2007	Company Son				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 19, Joyce G. Mitchell November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Manor Care Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 7, 1942 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2√2 F Maryland 218-40-7506 65 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be Is 3306 Delpha Court 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🍇 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Scheiber Marie Beatty ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Mitchell-spouse 3306 Delpha Court-Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Nov.24,2007 Timonium, Maryland Gardens
22. Name and Address of Facility 8800 Harford Road
EVANS FUNERAL CHAPEL Parkville, MD 21234
AND CREMATIONS SERVICES Parkville, MD 21234 Nov.24,2007 Timonium, Maryland 21. Signature of Funeral Service Licensee andrae 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Phoumonia piration Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) yopathy & Encephalopathy Examine that the death certificate be executed burial-transit physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐Unknown 9 Unknow signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗀 Yes page 2 should Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 XNo ghorexia 1 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of Injury (Month, Day Year) o the Hospital or Attending Pi ithin 24 hours after death. o the Funeral Director: After the empletely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💆 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

120061485

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bushva I, AL. Azzawi, MD, 9103 Franklin Sq. Dv. Suite 301, Bulb. MD 21237

5 Ste

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State 31. Date filed (Month, Day, Year)
Registrar

32. Registrar's Signature

V 2 7 2007 100 100 ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Dav Physician Robert Donald Malvaso 10:00 P.M 11 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 12/2/1939 Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 213-36-4316 67 Director Balt.,Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America "natural", or items 23a or 206 Duke of Kent Court Apt. 104 21030 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental Frank Malvaso Elizabeth Lipper ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 206 Duke of Kent Court Apt. Thelma J. Malvaso/ 104 Cockeysville, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans funeral 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages ' Department of H Important: If ite November 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 200 Forest Hill, Maryland <u> Chapel- Bel Air</u> 21. Signature of Faneral Service License 22. Name and Address of Facility / Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part. Enter the disease, or conscications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Immediate Cause (Final (iver 51 Physician months resulting in death) /Medical Due to (or as a consequence of) Examiner patitis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) .O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 ☐ Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 \( \sum \) No 1∐ Yes or Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier 1-certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) November 22, 2007 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed caused death (Item 23a) (Type, Print)

11) A Riley (-Bon 6701 N. Chule St. Balto. Md 2120) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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COVER

07-08929 Joyce Moore

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

byce Moore		ી- For State	e of Maryland / De		te of Death		ıaı mygı	ierie			
Physicis		Registrar  1. Decedent's Name (First, Middle,L		oei unca	e or Death		12.	Reg Date of Death	g. No. 2	00	3. Time di Death
Physicia ledical Exami	nar							Month November		ar	1120 hrs
r-,		4a. Facility Name (if not institution,	give street and number)		4b. City, To	own, or Location of			4c. County		
and .		1749 Waverly Way Apt.	E		Baltim	ore				1	A/N
uneral				rs. last birth	day) If Under			. Date of Birth	(MM/DD/YYY	<ul><li>Y) 9. Birth</li><li>Foreign</li></ul>	nplace (State or
Director		214-64-8706 1	M 2_xF 52		Yrs.	Days Hours	IVIIII.	05/02	2/1955		intry) MD
à.		Usual Residence of Decedent  10a. State 10b. County	100.0	City, Town o	Location						10d. Inside City Limits
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daryland 28a-f show 1 at once,	ţ	10e. Street and Number		Dare.	10f. Zip (	Code		10	g. Citizen of W	hat Coun	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	Director		y Way Apt.	E	1	239			U.S.		,
with the state of		11. Marital Status	12. Was Decedent Ever i	n U.S.	13. Was Deceder	nt of Hispanic Orig	gin? (Speci	fy Yes or No-	14. Rac	e - Americ	can Indian, Black,
death r iten	Funeral	1 Never Married 2 Marri	ed Armed Forces?  1 Yes 2 N	lo	If Yes, specify	Cuban, Mexican	, Puerto Ric	an, etc.)	Whi	te, etc.	
after	by F		ed If Yes, Give Year or Dates:		1 Yes 2					Bla	
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5-0036 led within 72 hou Hygiene. I other than "nat the Medical Exa	Completed	Elementary/Secondary (0-12)  1 2	College (1-4 or 5+)	I	Domesti	C			Own	Home	9
5-00 led with Hygiene other	E O	17. Father's Name (First, Middle, La	ist)			18.Mother	's Name (Fi	rst, Middle, M	laiden Surnam	e)	
21215-0036 uld be filed within 7 Mental Hygiene. narked other than c event, the Medica	Be (	Reginald <del>He</del>	lder Holde	20		Far	nnia	Threa	++		
D 21 hould nd Mer is man	ဥ	19a. Informant's Name/Relationship	(Type, Print )	19b.	Mailing Address	(Street and Num	nber or Rura	al Route Numi	ber, City or To	wn, State,	Zip Code) 21117
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ages I and 2 shount of Health and Its If them 27 is rother traumatic		20a. Method of Disposition  1 Burial 2 Cremation			Disposition (Nam y or other place)	•		ate	20c. Location	- City or	I own, State
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Baltimore, permit. Pages I al Department of He Important: If ite		21. Signature of Func al Service Lit	assis		22. Name and /	Address of Facility	<sup>y</sup> Chat	man-H	larris	FUr	neral Home
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/Medical		failure. List only one cause on				-, <b>3</b> ,					Between Onset and Death
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequent	ce of):							L.
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Box 687  death certific  the attending p	ician/	past 12 months?	4 Pregnant at time of	of 5	Other (Spec		3				.,
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1 of Vital Recing Physician: The land	P	1 Yes 2 No	1 Inpatient 2 28a. Date of Injury		patient 3 D0	8c. Injury at Work	Nursing H		Residence 6		Scene
Division of Vital Records, lal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should to	io	1 ✓ Natural 5 Pending	(Month, Day,Year)		,	1 Yes 2	, i		,,		
r Atte	ficat	2 Accident Investig 3 Suicide 6 Could n	28e Place of Injury -	At home, fan	m, street, factory,	office building, et	tc. 28	f. Location (S	treet and Num	ber or Ru	ral Route Number, City
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Phys	ician: To the best of my know								
Fo the within Fo the comple	Medical		ner:On the basis of examination and manner stated.	on and/or inv				e time, date a			
	Σ	29b. Signature and title of certifier	1		29c.	License number					nth, Day, Year)
<b>A</b>		1 aulor	Lell )			O.C.M.E.			Novembe	r 19, 20	JU <i>1</i>
i 🔴	İ	30. Name and address of person when I aron Locke MD. Ass			Penn Street,	Raltimore M	ID 21201				
	ata		istant Medical Examin		emi street,	Daiminore, IV	12 Z 1201				
Regist	ate rar	31. Date filed (Month Day Yzr) 7	2007	ر الله	Sparel						
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DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene 37598 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dorothy L. Messina November 7:16 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riverview Nursing Center Baltimore Baltimore 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 90 Yrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) December 2, 1916

9. Birthplace (S Country)
Mary Land Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 ☑ F 215-28-7953 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 7 is marked other than "netural", or items 23a or 28e-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Maryland Baltimore Lutherville Funeral Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Dublin Drive 21093 **USA** 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 Completed by 1 ☐ Yes 2 ☑ No Specify White 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry A College (1-4or 5+) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) Saleslady Department Store Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lewis McCracken Amelia Doler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Messina, Jr./Son 103 Dublin Drive Lutherville Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillton Service Corp. 11/26/07 Towson Maryland 22. Name and Address of Facility Leonard J. Ruck. Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical an. Kum Examiner Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, ending physician a ruse as the burial Physician/Medical Due to (or as a consequence of): jo Division of Vital Records, P.O. been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 □ No 3 □ Probably 4 □ Unknown Completed by page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has After this certificete 1 ☐ Yes 2 10 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ō within 24 hours e Hospital \*\*Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) M-D. 11-23-2007. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D-21221. 709. EASTERN BLUD. MALIKA WASERM. istrar's Signatur 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

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		1	For State Registrar			rtificate o			g. No. 2 1 1	7 27500		
Die	hysicia	_	. Decedent's Name (First, Middle, Last)					2. Date of Death Month	$e^{\text{Day}}$ 20, $2^{\text{Vo}}$	ar 3:- Time of Death		
	/Medic	al -		lin F. Mo	Manis	4h Cihi Tour	, or Location of D		4c. County of E			
E	xamine	er '	a. Facility Name (If not institution, give street at 2757 Yarnall Road	and number)			timore	reall		imore		
Fur	neral		Social Security Number 6. Sex	rs. last birthday)		ar If Under 24	Hrs. 8. Date of Birth Vin. (Month, Day,	1 9	Birthplace (State or Foreign Country)			
Dire	ector		372 22 4273 1 <sup>1</sup> M <sup>2</sup>	□F   82	Yrs.	monaro say	110010	Jan. 4,	1925   M	laryland		
land	a ti	1-	Jsual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation			an order	10d. Inside City Limits		
Many a-fsh	ified	ctor	Maryland Baltimore		Baltimo	re				1 □ Yes 2 □ No		
ith the	pe no	<u></u>	Oe. Street and Number			10f. Zip Code		10	Og. Citizen of Wha			
eath v	nust must	Funeral	2757 Yarnall Road	as Decedent Ever i	n U.S. 13.		1227 of Hispanic Origin	? (Specify Yes or No-	U.S.A.	American Indian,		
<b>5</b> after d	ulner	Fun	An	med Forces? □Yes 2 🕱 No /es, Give ar or Dates:		If Y <i>e</i> s, specify C 1 □ Yes 2 ☑ N		? (Specify Yes or No- Puerto Rican, etc.)		Vhite, etc.		
303( ours a	Exal	db							Specify: White			
15-(in 72 h	edica	Completed	15. Decedent's Education (Specify only highest grade comp		16a. Dece (Give life.	dent's Usual Occ kind of work do DO NOT use ret	cupation ne during most of ired)	f working	16b. Kind of Busin	ess/industry		
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be file tal Hy	event,	Be	17. Father's Name ( <i>First</i> , <i>Middle</i> , <i>Last</i> )	2011				Name (First, Middle, M	Maiden Surna <b>m</b> e)			
ryla hould d Men	natic	ဍ	Earl McMa		19h Maili	na Address (Stre		lie Crowe or Rural Route Number	City or Town Sta	te Zin Code)		
Mal nd 2 sl utth an	r traur		Dorothy McManis / N			Yarnall		Baltimore	•			
or Heg	r othe	ŀ	20a. Method of Disposition	20 al from State	b. Place of Dispo	osition (Name of matory or other)	place)		20c. Location - Cit			
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene.	jury o		1 ☑ Bunal 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	M M		_				, Maryland		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the 27 is marked other than "natural" or items 23a or 28a-f show	any in		21. Signature of Funeral Service Licensee	murus	40	001 Ritc	hie High		more, Man	ice, P.A. ryland 21225		
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the cause on each line.	leath. Do not en	ter the mode of	dying, such as ca	rdiac or respiratory arre	est,	Approximate Interval Between Onset and Death		
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Box 68 sath certificat	or use	Physician/Medio	23b. Was decedent pregnant 11	yes, outcome pf pro □Live birth 2 □ □Pregnant at time	Fetal death 3[	☐Ectopic pregna☐Other (specify			23d. Date o Month	,		
P.O.	been signed by the attending phy should be detached for use as the	ysic		Unknown	ordeam 5		/					
S, P	gned p	by PI	Part II. Other significant conditions contribut	ing to death but not	resulting in the u	nderlying cause	given in Part I.		1	ite to the cause of death?		
ord requir	hould	eted				· · · · · · · · · · · · · · · · · · ·		1Ye	*	☐ Probably 4 ☐ Unknown		
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tal an: T	tiricate tor, pa	Be Co	25. Was case referred to medical				26. Place of	1  Yes f Death (Check only on	7	Yes 2□No		
nr V	direct	To B	examiner? 1 ☐ Yes No Hospit	al: 1	2 □ ER/Outpatie	III 3 DOA		ing Home Reside	ence 6 □Other	(Specify)		
on o	Aner 1 funera	on:	1 Natural 5 Pending	a. Date of Injury (Month, Day Yea	ar) 28b. Time o		njuryat Work? 1 ∐ Yes 2 ∐ No		ow injury occurred			
/iSiC Attend death	y the	ficat	3 Suicide 6 Could not be 28	e. Place of injury -	At home, farm, st			28f. Location (St		or Rural Route Number,		
Div tal or v	ed in b	Certification:	4 Homicide determined	building, etc. (Sp	эеспу)			City or Towi	n, State)			
Division or Vital Residue to the Hospital or Attending Physician: The Within 24 hours after death.	ne rune pletely fil	Medical	29a, Certifier (Check only one)  Certifying Physician  Certifying Physician  Medical Examiner:					occurred at the time, o	late and place, and	d due to the cause(s)		
To the	L COM	Ž	29b. Signature and title of certifier	orbid	in one	29c. Lic	ense number 2743	8 /	Voulen G	Month, Day, Year)  EV 21,2007		
	6		30. Name and address of person who completed the state of	- an	(Item 23a) (Type	Print)	al Orice	Glea B	race pul	Nonth, Day, Year)  21,2007  21061		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	1 6				ţ		
R	Registr	ar	NOV 2 7 2007	Mayer	JE A	could						

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 22**,** 2007 4:55 Malstrom November  $P^{M}$ Robert Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6303 Orchid Drive Montgomery Bethesda 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1XM 2□F 86 372-14-0147 Director May 31, 1921 Michigan Usual Residence of Decedent la or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits 1 ☐Yes 2 X No Director Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 6303 Orchid Drive 23a 20817 United States "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No WWII Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Chief Financial Clerk Senate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it and 2 should be fill Health and Mental H tem 27 is marked oth Be Carl J. Malstrom Tena Anderson ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ... Pages 1 and Pearl B. Malstrom / Wife 6303 Orchid Drive, Bethesda, Maryland 20817 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November permit. Pages Department of Important: If i any injury or once, = 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 26, 2007 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. Robert A. Pumphrey Funeral Home / Bet 7557 Wisconsin Avenue, Bethesda, Ma

23a. Parti Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ф in the past 12 months? Year Month Day 5 ☐ Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by History of Bladder Cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 2 X No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death Check onl one 1 ☐ Yes 2 📉 No Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 🗀 Inpatient this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatufe and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064615 November 23, 2007 20+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, Rockville, Maryland 20850 Genevieve Wroblewski, MD 2. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 2 7 Registrar

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

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	1 - State Registrar	State of Ivia	rylanu / I		tificate of L			Reg. N	000	7	37	601		
ian	1. Decedent's Name (First, Middle, La	•					2. Date of De Month		3. Time of					
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ner	4a. Facility Name (If not institution, given 1004 Crawford D				4b. City, Town, or Rockvil			4	Monta					
a -			(In yrs. last bi	rthday)_	If Under 1 Year	8. Date of Bi	 rth	Montgomery  9. Birthplace (State or Foreign Country)						
	579-96-1808 Usual Residence of Decedent	1□M 2 <b>K</b> IF	45	Yrs.	Yrs. Months Days Hours Min.			(Month, Day, Year) Aug. 2, 1962  Korea						
	10a. State 10b. County		10c. City, Tow	n or Loc	ation					10	d. Inside Ci	ity Limits		
tor	Maryland Montgo	mery	Rockv	ille							1 X Yes	2 □ No		
<b>Funeral Director</b>	10e. Street and Number							10g. Citizen of What Country?						
<u>e</u>	1004 Crawford D	rive	20851					U	nited States					
nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - American Indian, Black, White, etc.					
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ပိ	17. Father's Name (First, Middle, Las.				Teache	18. Mother's Nam	e (First Middle				. 10			
Be	John P. Muldoon	<i>'</i>				Patricia		,						
မ	19a. Informant's Name/Relationship	(Type, Print)	198	o. Mailing	Address (Street a				<b>.</b>	ate Zin	Code)			
	Genevieve M. Mul				Crawfor							51		
	20a. Method of Disposition		20b. Place o	f Dispos	ition (Name of		Date		Location - Cit			<u> </u>		
	1 Burial 2 MCremation 3 Removal from State 4 Donation 5 Other (Specify)    Montgomery Crematorium   November 23,   Bethesda, Marylan													
	21. Signature of Funeral Service Lice	. // ,	101173	Ro1 300	Name and Addres bert A. Pu O W. Montg	mphrey Fun comery Aven	eral Hom we, Rock	e, R vill	ockville e, Mary	e, Ir land	nc. 20850			
	23a. Part1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on tach line.  Approximate Interval Between													
	Immediate Cause (Final disease or condition  Metastatic Breast Cancer to Liver  1 yr. + 1m													
	resulting in death)  Due to (or as a consequence of):													
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ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c													
хап	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):										
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edic		d												
No.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy	_					23d. Date of	of delive	rv			
icia	in the past 12 months? 1 ☐ Yes 2 █ No	1□Live birth 4□Pregnant at			Ectopic pregnancy Other <i>(sp</i> ec <i>ify)</i>				Month		-	Year		
Physician/M	9 □ Unknown	9□ Unknown					- 0							
y P	Part II. Other significant conditions	contributing to death bu	t not resulting i	n the und	derlying cause give	en in Part I.	23e. Did	tobacco	o use contribu	ite to th	e cause of c	death?		
edk							10	Yes	2 <b>X</b> No 3∣	☐ Proba	ably 4 ⊡l	Unknown		
plet							4a. Was an 24b. Were autopsy finding autopsy				available			
Completed by							perf 1 Yes	ormed?						
Be C	25, Was case referred to medical examiner?					26. Place of Deat								
To	1 ☐ Yes 2X No	Hospital: 1   Inpatie		utpatient		4 Li Nursing H	ome 5 <b>∏</b> Res	idence	6 □Other	(Specify	)			
ü	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Injury Work		28d. Describe	how in	jury occurred					
cati	2 Accident investigation 3 Suicide 6 Could not be	20				Yes 2 □ No								
rtiffi	4 Homicide determined	28e. Place of inju building, etc	ry - At nome, to . (Specify)	arm, stre	et, factory, office		28f. Location (			or Rural	Route Nurr	ıber,		
2	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
Medical Certification:	Centified (Check only one)    Check only one   Check one   Check only one   Check only one   Check only one   Check one   Check only one   Check one   Check one   Check one   Check one   Check one   Check one													
Ž	29b. Signature and title of certifier	2 11	4		29c. License				Date signed (					
	mohr	12 Visa	drud		D37	236	:	No	vember	19,	2007			
	30. Name and address of person who			-/		- D -1	. 1 . 1		1 0	2017				
	Carolyn Hendric 31. Date filed (Month, Day, Year)	KS, M.D. (	941U KO	скте	dge Drive	e, Bethes	saa, Ma	ryla	and 20	0817				
ato.		o <u>a</u> negistra	r's Signature	-										
ate rar	NOV 9 17 20	n7 Registra	r's Signature	dos	100									

1. Decedent's Name (First Middle Last)

Marian T. Mehrling

4a. Facility Name (If not institution, give street and number)

**Physician** 

/Medical

Examiner

Sunrise of Silver Spring Silver Spring
If Under 1 Year If Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex . Age (In yrs. last birthday, **Funeral** Hours 1 ☐ M 2 🗓 F 93 Director 577-07-9392 February 22, 1914 Washington, D.C Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20882 22137 Creekview Drive Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Department Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other thrainmain injury or other trainmains. 12 of Agriculture Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Richard Tydings Dora Irene Schuyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22137 Creekview Drive, Gaithersburg, MD 20882 Charles Kenneth Mehrling / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State November 4 □ Donation 5 □ Other (Specify) 24, 2007 Montgomery Crematorium Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Rockville, Inc., 300 West Rockville, Maryland 20850 Pumphrey Funeral Home/ Montgomery Avenue, -2805 M01473 | Rockville, Inc., 300 West Mo Rockville, Maryland 20850–28

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Bilateral Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown sate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fraility, Dementia: Advanced, Osteoarthritis, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No <u>Hypertension</u>, Malnutrition autopsy performed? 2K No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Assisted P 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 28c. İnjury at Work? Certification: 1 X Natural 5 Pending investigation within 24 hours after deam.

To the Funeral Director: After the funeral on the funeral properties of the funeral propertie 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signatura and title of certifier 29d. Date signed (Month, Day, Year) D53362 November 19, 2007 iU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave., #1-17, Silver Spring, Maryland 20902 Shyamsundar Rajan, M.D31. Date filed (Month, Day, Year) NOV 2 7 . Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City. Town, or Location of Death

2. Date of Death

November

18, 2007

4c. County of Death

1:45

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

nours after death.

neral Director: After this
y filled in by the funeral di

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ravi Passi, M.D., 8609 Second Ave., Suite 404B, Silver Spring, Maryland 20910

and manner stated.

31. Date filed (Month, Day, Year) State NOV 2 7 2007 Registrar

4 Homicide

and title of certifier

29a. Certifier

29b. Sjynatur



🛮 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D28656

29d. Date signed (Month, Day, Year)

November 26, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dav 9:30 AM Dorothy Theresa McElroy 25 /Medical 2007 4a. Facility Name (If not institution, give street and number) Franklin Square Hospital 4c. County of Death Examiner 4b. City, Town, or Location of Death Rosedale Baltimore Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🗷 F Months Director 213-26-6833 79 Oct. 17, 1928 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits MD Director Baltimore Parkville 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800. Completed by Funeral Walther Blvd. #3514 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian filed within 72 hours after Hygiene. Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Yes 21X11/vio Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White permit, Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Joseph Basel Alberta Gunther 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) McElroy (spouse) John Thomas 8800 Walther Blvd. # 3514 Parkville, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 11/28/2007 4 □ Donatie 5 Other (Specify) Baltimore, Maryland f Funeral Service License 21. Signature 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21204 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) schemic **Physician** /Medical Due to (or as a consequence of): Examiner Me Senteric Artery Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) Day Year 1 ☐ Yes 2 ☐ No been signed by the should be detached 9∏Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 🗖 Inpatient Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,  $\mathscr{C}_{\mathcal{S}}$ within 24 hours a To the Funeral I completely

> State Registrar

DHMH 17 Rev 1/2001

9000 Franklin Square Drive Balto, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

ota

32. Registrar's Signature

r. Summit

NOV 27

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 NADINE NEWTON /Medical 4a, Facility Name (If not institution, give street and number 4c. County of Death Examiner Hospital Center Baltimur uspaale If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F **Director** MARCH 17,1927 220-22-6860 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MIDDLE RIVER MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21220 Funeral 609 KINGSTON ROAD Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced BLACK. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If item 27 is marked other ti amy injury or other traumatic event, the once. HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BARBARA McCOY FREDERICK NEWTON ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 KINGSTON RD. BALTIMORE, MARYLAND 21220 VALERIE MABRY/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL PK. 11-29-07 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician oracic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) physician Physician/Medical the as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day in the past 12 months? Year 4☐Pregnant at time of death 5 ☐ Other (specify) led by the a 1□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 217 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury s after death. il Director: After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and planner stated.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a To the Funeral C

NEWHON, NAGINE altimore, Maryland 21215-0036

State Registrar

NOV 2

29b. Signature and title of certific

30. Name and address @ person who co 31. Date filed (Month, Day, Year)

2007

npleted cause of death (Item 23a) (Type, Print) #32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

ware Drive Baltimore, MD 21237

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** SIZ VOVENDEN 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In. vrs. last birthday) **Funeral** 110 M 2□ F Months Days Hours 8 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No a 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) disa 10H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Owens e 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) phin St ot.410 Owens 501 Joan Dol 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State don 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final disease o condition resulting in death) **Physician** MOWN /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 687605 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by TE Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy After this certificate 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, Hospital: 1 ☐ Yes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 No death. within 24 hours after death To the Funeral Director; and completely filled in by the f Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

3

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar

32 Registrar's Signature

and a dress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 24, Physician 5:30 a M Robert Joseph 0'Connell 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Joseph Manor 911 W. Lake Ave. n/a Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Sept 5, 1906 **Funeral** Days Hours 1**X**1M 2□ F Newryork 126-05-7494 101 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County r 28a-f show notified at 1 LYYes 2 L No MD Director n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or U.S.A. 911 West Lake Avenue 21210 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roman Catholic Priest Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0'Connell Edward Josephine McLaughlin ဥ 19a. Informant's Name/Relationship (Type. PrintFellow Priest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Joseph Soc. of the Sacred Heart 1130 N. Calvert St., Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State New Cathedral 11-27-07 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fungral Servic Licensee William G. Dau | 22. Name and Address of Facility Leonard J. Ruck, Inc. un 5305 Harford Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 'neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician ar Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: D/A-23b. Was decedent pregnant in the past 12 months? 3 Ectopic prégnancy 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery Month Day signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ ▼0 s certificate has t lirector, page 2 s 1□ Yes 2 100 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 ☐ Yes 21 NO 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ို this After thi 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury 1 TYes 2 TNo after death Director: / 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in

State Registrar

29a. Certifier

JOHN T. EVELIUSKD

31. Date filed (Month, Day, Year) NOV 2 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Medical

DHMH 17 Rev 1/2001

(a) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29c. License number

00034952

7600 OSLED DRIVE Swite 308 Towaw, HARPLAND 21204

29d. Date signed (Month, Day, Year) 11/26/2007

alter Peopl	es		I- For State	ate of Maryl		artment of <i>rtificate of</i>			Mental H		Reg. No.	20	07	3	760		
Phys	icia		Registrar 1. Decedent's Name (First, Midd	e,Last)						2. Date of De	ath		- 1	Time of I			
ical Examine			Walter			Peoples						Month Day Year November 20, 2007			1824 hrs		
			4a. Facility Name (if not institution 517 North Potomac S	_	umber)		tb. City, T Baltin		ocation of Death	1	40	c. County of D	eath				
F			5. Social Security Number	6. Sex	7. Age (In yrs. I	ast hirthday)		er 1 Year	If Under 24Hrs	s. 8. Date of E	Sirth (NAM	NA	Birthola	ace (Stat	e or		
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any	}	ŀ	10a. State 10b. County		10c. City	, Town or Locat	on						10	d. Inside	City Limits		
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Maryland 28a-f show	at or	Director	10e. Street and Number		- '		10f. Zip Code					10g. Citizen of What Country?					
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	the M	Š	17. Father's Name (First, Middle						.Mother's Name	e (First, Middle	, Maider						
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Should and Ma	atic e	2	19a. Informant's Name/Relations					•	and Number or								
MD and 2 sho salth and em 27 is	Tage.		Marilyn Peopl 20a. Method of Disposition	.es w	ife I20b	Place of Dispos			c Stree	Date		re, Md		21205 vn. State			
Baltimore, bermit. Pages 1 ar Department of Hee Important: If ite	or other traumatic event, the Medical Exa		1 X Burial 2 Cremation	n 3 Removal f	from State	crematory or ot	ner place)		,				•				
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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygener Important: If item 27 is marked other thingury or other traumatic event, the Medical property.			21. Signature of Funeral Service	Licensee	,			Address o	orth Ave	March	F.H.	East	_	21202	,		
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x 68 h certi	for use as the	sician/M	2 Sol. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)								25/4/14	Wichan	Day		100.		
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<b>ord</b> aw req as bee	plnous 2	24a. Was an autopsy performed 1 Yes 2 ✔								opsy							
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed eath.  Our: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transi	page	5									2 🗸 1		Yes	2	No		
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DIVI	<u>.</u> =	틝	dete	d not be Specify		one, ram, suc	st, lactory	, office but	iding, etc.	or Town		and Number c	Tturai	rtoute 14	amber, only		
DIV Hospital or 24 hours afte Funeral Di	aly fill		4 Homicide 29a. Certifier 1 Certifying P	hysician: To the be		lge, death occur	red at the	time, date	and place, and	due to the ca	use(s) a	nd manner as	stated				
# E #	completely	Medical	Toncon only	miner:On the basis	of examination a									ause(s)			
To viet	3	Σ	29b. Signature and title of certific	and manner	siateu.		290	. License		10.45	29d.	Date signed	(Month,	Day, Ye	ar)		
		O.C.M.E								.M.E. OCME			November 23, 2007				
T			30. Name and address of person	who completed car	se of death (Item	n 23a)					1						
10 '	-	l	Theodore M. King, Jr.	, MD. Assist	ant Medical I	Examiner	111 Pe	enn Stre	et, Baltimor	e, MD 212	01						
	0.0	ate	31. Date filed (Month, Day, Year)	32. R	strar's Signat	ure											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene OF Certificate of Death 37609 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 23 2007 5:00P.M Nov. Dorothy Marie Powers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 2908 Old Joppa Road Joppa If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/25/1914 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Days Months Hours Director 93 215-09-8494 Baltimore MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatlth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XXIo Funeral Director Harford Joppa MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2908 Old Joppa Road 21085 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 Y You If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify:white 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maryland Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk State Police 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Kunkel Gantz Marry E. Appel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: if item 27 is any injury or other trau once. 2908 Old Joppa Rd., Joppa, MD 21085 James Powers - son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bel Air 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27/07 Bel Air, MD 4 ☐ Donation 5 ☐ Other (Specify) ardens and Address of Facility Mcmoria 21. Signature of Funeral Servic 11 ense 3 Newport Dr · Forest Evans Funeral · Chapel & Kin e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disea shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or con resulting in death) **Physician** Demenha Gears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-trar and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown after death.

Director: After this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31295 11/26/42

State Registrar

DHMH 17 Rev 1/2001

Zowsan

mad

21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sinte

32 Registrar's Signature

4202

charles

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month lizabe /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St ove Hai toro 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Mpnth, Day, Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 😿 F Hours Year) Massachusett Director 4/11 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be r 210 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Mental I item 27 is marked or 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20a. Method of Disposition 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Darlington permit. Facility 3 New Ant A. Forest Hill 21057 21. Signature of Funeral Service License 22. Name and Address Evanstineial 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a construence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an page 2 s performed? Hospital or Attending Physician: in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation ↑ Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 032299 Ne-ent-21, 2002 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belair a. raco 20 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygien 2007 376 | |

		-	For State Registrar	State of Marylai		inment of F tificate of t			eg. No.	07011
	· ·		Decedent's Name (First, Middle, Last	)			2	2. Date of Deat	h Day Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	
			5. Social Security Number 6. Se		. last birthday)	Park u	If Under 24 Hrs.	B. Date of Birth	9. Bi	rthplace (State or Foreign
	Funeral Director			□M <b>¾(X</b> F 90	Yrs.	Months Days	Hours Min.	Month, Day June 29	9,1917 Pe	nnsylvania
	aryland show	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes ♣ No
	28a-f	Director	Maryland Bal	timore		10f. Zip Code	Rosedale		Og. Citizen of What C	country?
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/lar	Venta Venta Venta vrked	To E	Jacob Oberhol	tzer				Anne K		
Maryland	nd 2 should be filed within " Ith and Mental Hygiene. 27 is marked other than " traumatic event, the Me.		19a. Informant's Name/Relationship (7 Sheila Bailey	ype, Print) (Friend)	19b. Mailir 4506	ng Address <i>(Street</i> 5 Golden	and Number or Rural Meadow Roa	Route Number ad B <b>al</b>	r, City or Town, State, timore, Ma	Zip Code) aryland 21128
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_	ding p		fF FEMALE:	23c. If yes, outcome of preg	inancv				23d. Date of c	lelivery
.O. Box	requires that the death certifi een signed by the attending hould be detached for use as	Completed by Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etaf death 3	Ectopic pregnanc Other (specify)	у		Month	Day Year
0	s that the ned by a detail	y Ph	Part II. Other significant conditions of	ontributing to death but not re	esulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w requires been sign should be	q pa	CHF		Chrone	i gum	16	1 🗆 Y	'es 2 ₽No 3 □	Probably 4 □Unknown
of Vital Records,	S S	plet	rend insufficiency					24a. Was	sy prior t	autopsy findings available o completion of cause of
I.R.	The ate h page	Com	Cardiomycrathy						rmed? death	? es 2□ No
/ita	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	11			26. Place of Death	1000		
) <del>_</del>	hysi this c	၉	1 ☐ Yes 2 ☐ Ño	Hospital: 1 Inpatient 2		IL 3 DOA			lence 6 □Other (Sinow injury occurred	pecify)
on c	ng fter inel	tion;	27. Manner of Death  1 ☐ Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of fnjury (Month, Day Year)	28b. Time o Injury	Wo	ryat irk? ]Yes 2 □No	ad. Describe i	low injury occurred	
Division	or Attanding I fter death. Sirector: After in by the funer	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		home, farm, st cify)			28f. Location (5 City or Tox	Street and Number or vn. State)	Rural Route Number,
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai Ce	(Check only 2 Medical Exam	ysician: To the best of my k	nowledge, deat	h occurred at the to	ime, date and place, a opinion, death occurre	and due to the ed at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
	thin 2 thin 2 the imple	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)
	F ≥ F 8		> Wend Ke	alx mo		DS			11/2/107	
7			O -	<u> </u>						
7	6		30. Name and address of person who	completed cause of death (It	tem 23a) (Type,	Print) JA 4202	70 wson	md	21204	
	5 Sta Regist	ate	30. Name and address of person who Wands Klots and St. Otto St. 31. Date filed (Month, Day, Year)		tem 23a) (Type,	Print)  J. K. Y 202	70wson	md	21204	

		Please T	ype or Print in B						gible.	
		For 1 _ State	State of Marylan		ertificate of I		-	giene Reg. No. 2	007	37612
		Registrar  1. Decedent's Name (First, Middle, Last)		CE	er tillicate or t	Jeani	2. Date of De		007	3. Time of Death
Physic		T. Dooddon't Haine (Firely Impare) and	Catherine	I.	Polen		Month November	Day er 22.	Year 2007	11:30 A <sup>M</sup>
/Medi Exami	· 1.65	4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death			unty of Death	
		Stella Maris Hosp  5. Social Security Number 6. Sex		lact hirthda	Timon	ium If Under 24 Hrs.	8. Date of Bir		timore	blace (State or Foreign
Funeral Director			м ждғ 88	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)	Cour	nsylvania
yland Jow at		10a. State 10b. County	10c. City	y, Town or l	_ocation				1	10d. Inside City Limits
e Mar 3a-f sk tiffied	Director	Maryland Balt:	imore			Dunda	lk			1 Tyes 2 No
with the	Dire	10e. Street and Number	-		10f. Zip Code	1222			of What Cour ed Sta	
leath ns 23 must	Funeral	1940 Holborn Ro	12. Was Decedent Ever in U.	S. 13	3. Was Decedent of H If Yes, specify Cuba		pecify Yes or No		Race - Americ	can Indian,
after or iter		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:	o Aican, etc.)		Black, White, pecify:	
hours ural",	d by	3 🖫 Widowed 4 ☐ Divorced	Year or Dates:	16a Dec	edent's Usual Occup	ation			Wh : of Business/In	ite
in 72 n "nat hedice	plete	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Giv life.	ve kind of work done DO NOT use retired	during most of wor il)	king			,
d with giene er thau	Completed	11 Years	College (1-401 3+)	Į v	Vaitress				staura	nt
be file ttal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne <i>(First, Middle</i> Kosceln:		rname)	
lary laint ZIZIO-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	오	Frank Shinal  19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Ma	iling Address (Street				own, State, Zij	o Code)
ire, INIGITY INITION AT LICENOISO  If and 2 should be filed within 72 hours after death with the Marylan If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Mr. Daniel H. Pol		15 V	Weyfield C	ourt Ro	sedale,	Maryl	and 2	1237
es 1 and 2 of Health a of Health a filtern 27 is		20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ F		Place of Dis cemetery, cr	position (Name of rematory or other place	1	Date		tion - City or T	
Dallillo		4 □ Donation 5 □ Other (Specify)	0:		vn Cemeter	( F 10) h .				Maryland
Dalltillore permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21, Signature of Funeral Service Licens			Duda-Ruc	ss of Facility k Funera se Ave.				
	<	23a. Part1 Pinter the dise se, or complete the control of the cont	lications that caused the deat	h. Do not e	enter the mode of dyin	ng, such as cardia	c or respiratory a	arrest,	TAIIU Z	Approximate Interval Between Onset and Death
Physician	ı	Immediate Cause (Final disease or condition resulting in death)	a. DEMENTIA							Onset and Death
/Medical Examiner		resulting in deality	Due to (or as a conseq	uence of):						
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box death car	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \text{Yes} \) 2 \(\begin{array}{c} \begin{array}{c} \begin{array}{	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death	3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	у			Month	Day Year
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Cords, P.O. BOX or wrequires that the obath curtific been signed by the attencing pshould be detached for use as	þ	Part II. Other significant conditions co	entributing to death but not res	sulting in the	e underlying cause gr	ven in Part I.				bably 4 Unknown
Hecord he law require has been sige 2 should to	Completed						24a. Wa	s an opsy formed?	24b. Were aut prior to c death?	topsy findings available ompletion of cause of
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Or VITAI Physician: 1 this certificat ral director, pi	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpat	tient 3 DOA Otl	nor:	Home 5☐Res		Other (Spec	ify) HOSPICE
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SIC ten teath tor:	catic	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At h	some farm		Yes 2 No	28f Location	(Street and I	Number or Ru	ral Route Number,
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UIVI  To the Hospital or At within 24 hours after d  To the Funeral Direct completely filled in by	Medica! C	29a. Certifier (Check only one)	ysician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, de ation and/o	eath occurred at the t r investigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time	e cause(s) a e, date and p	nd manner as lace, and due	stated. to the cause(s)
To th within To th	Me	29b. Signature and title of certifier			29c. Licen	se number			signed (Month	
		30. Name and address of person who o	completed cause of death (Ite	m 23a) (Tvr		, , ,		- 11	123/0	
5		DR. TARIQ MAHMOOI	2300 DULANI	EY VAI		TIMONIUM	, MD 210	093		
	tate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	backs					
Regis		NOV 2 7 20	UI JOSEPH S	19	-					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** ΑM November 16,2007 10:38 John Querfurth, Jr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 2404 Cider Mill Road Parkville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Nov. 18, 1922 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** 1X M 2□ F Maryland 84 Director 218-18-9668 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a State 10b. County 1 ☐ Yes 2X No Director MD Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be r 2404 Cider Mill Road 21234 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23: any Injury or other traumatic event, the Medical Examiner must Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ ▼es 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Warren-Ehret Sheet Metal Worker Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matilda Otto John Ouerfurth ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2404 Cider Mill Road-Parkville, Maryland 21234 Jean Querfurth-spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery Nov. 20, 2007 Catonsville, Marylano 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
EVANS FUNERAL CHAPEL,
AND CREMATION SERVICES 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville, Maryland 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a I for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Ves 2 □ No ed by the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 20 No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Che Be Other: 1 ☐ Yes 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 ☐Other (Specify) P after death. in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manuer of Dea (Month, Day Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours at To the Funeral Completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medi 29d. Date signed (Month, Day, Year)

State Registrar Month, Day, Year)

NOV 2 7 2007

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year November 19, 2007 **Physician** Marjorie H. Rollins 11:00a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5616 Allcroft Road Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Days 218-28-3975 Director 18, 1930 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5616 Allcroft Road or items 23a 21227 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 ☐ Widowed 4 🎇 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is 1 and 2 should be filed within of Health and Mental Hygiene. College (1-4or 5+) Accountant Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig B. Rollins - Son 5616 Allcroft Road, Baltimore, MD 21227 20b. Place of Disposition (Name of West Arundel 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If Ite any injury or ot ☐ Burial 2 X Cremation 3 ☐ Removal from State 11-24-2007 Odenton, MD 4 Donation 5 Dother (Specify) Crematory 11-24-2007 Odelitoli, Fin 22. Name and Address of Facility Ambrose Funeral Home, Inc. Funeral Service 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DEBILITY 3 MONTHS disease or condition resulting in death) /Medical Examiner ILATERAL CEREBROVASCULAR ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MELLITUS physician and s the burial-trans Due to (or as a consequence of) HYPERTENSION Physician/Medical as signed by the attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, BLINDNESS 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed HISTORY OF DEED VEIN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performe THROMBOSIS OF THE LEFT LEG this certificate 2 XNo 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the Funeral Director: npletely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5808 MAIN STREET, ELKRIDGE KIM JA M.D 32 Registrar's Signature 31. Date filed (Month, Day, Year) NOV 2 7 2007 Registrar

		amend i  1 - For State Registrar	Type or Print in Black In 15 tem 8 per fth 887 ber fth	artment of H rtificate of L			giene Reg. No.	1 A A ===	37615
·Physi /Med		1. Decedent's Name (First, Middle, La Joseph F. Ridd				2. Date of De Month	Day	Year 2007	3. Time of Death 5:45a
Exam		4a. Facility Name (If not institution, given Stella Maris	re street and number)	4b. City, Town, or	Location of Death			County of Death	1
Funera Directo		5. Social Security Number 6. 3	Sex 7. Age (In yrs. last birthday) 11 ★ 2 F 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Bir (Mg)th, Da 2 - <del>5 =</del> 1	th ay, Year) 932	Cou	place (State or Foreign intry) yland
Aaryland F show ed at	٥	10a. State 10b. County  MD	10c. City, Town or Lo Baltimo						10d. Inside City Limits  ★ Yes 2 No
with the Na or 28a-	Director	10e. Street and Number		10f. Zip Code				en of What Cou	intry?
2. Should be filled within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Merikal Examiner must be notified at	by Funeral	155 South Grus  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No ▲ rmy	Was Decedent of Hilf Yes, specify Cuba		pecify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify: Wh:	, etc.
within 72 hour iene. than "natural the Medical Ex	Completed b	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation adde completed)  College (1-4or 5+)	dent's Usual Occup kind of work done o DO NOT use retired Ck Laye1	during most of work ()	king	1	d of Business/l hlehem	steel
2 should be filed with and Mental Hygiene. Is marked other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Las. Saul Ridolfi	t)	1	18. Mother's Nam			Surname)	
s 1 and 2 should Health and Mer tem 27 Is marke other traumatic		19a. Informant's Name/Relationship Billy (William	n) Hughes 27 1	ng Address <i>(Street a</i> Medici C	t. Park	ville	, MD	21234	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy) Sacred	osition (Name of matory or other place Heart M	11/3	Date 0 / 2007		ation - City or T	
permit. Depart Import any Inj	OUCE	21. Signature Funeral Service Lice	26		nkling_	St.Bal	timo		Jr. FH 21224 Approximate
Physician /Medica Examine	ıl	a. Parti. Enter the dis ase of conshots, or neart fair re. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death. Do not en one cause on each line.  a. MESOTHELIOMA  Due to (or as a consequence of):	ter the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Interval Between Onset and Death
e be executed sician and burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease of injury that initiated events resulting in death) Last	b		- A.				
The law requires that the death certificate be ate has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		⊒Ectopic pregnancy ⊒ Other (specify)	,		2	3d. Date of deli Month	very Day Year
uires that the de	þ	Part II. Other significant conditions	contributing to death but not resulting in the u	underlying cause giv	en in Part I.		tobacco us Yes 2□		the cause of death?
The law rec icate has beer r, page 2 shou	Completed					perl 1∐ Yes	opsy ormed? 2 No	prior to o	topsy findings available completion of cause of 2 ☐ No
To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s' completely filled in by the funeral director, page 2 should	Certification: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	De 280 Place of injury . At home form of	of 28c. Injur Wor M 1 🗆	4 ⊔ Nursing H	ome 5 ☐ Res 28d. Describe	idence 6 how injury	occurred	cify) <b>HOSPICE</b>
spital or A ours after ( eral Direct filled in by		4 ☐ Homicide determined	building, etc. (Specify)		me, date and place	City or To	iwn, State)		
To the Hospital within 24 hours a To the Funeral completely filled	Medical		iner: On the basis of examination and/or in and manner stated.		ppinion, death occu		, date and		to the cause(s)
7	(   -	1		D	4372	25-		11/26/	67
101		DR. TARIO MAHMOO	completed cause of death (Item 23a) (Type D 2300 DULANEY VALL)			MD 2109			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H	ealth and I Death	Mental Hygie	Comm Col Col S	37616
	Physici	an	1. Decedent's Name (First, Middle, Las Catherine	Marie	Reinha	rdt.		2. Date of Death Month	<sup>D</sup> 21, 2007	3. Time of Death 5:20 a M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Death	
			Manor Care-Ruxt  5. Social Security Number 6. So		ge (In yrs. last birthday	Ruxt	ON If Under 24 Hrs.	8. Date of Birth	Baltimo	place (State or Foreign
	Funeral Director			M 25√F 7. A	91 Yrs.	Months Days	Hours Min.	Feb. 9,	1916 Mary	land
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Marylan e-f show	tor	MD Baltim	ore		rkville				1 ☐ Yes 2 🂢 No
	th with the 23a or 28e ust be not	al Director	10e. Street and Number 10 Broadleaf Co	ırt		10f. Zip Code 2123	4	10g.	Citizen of What Cou	
980	72 hours after death with the Maryland netural; or Items 23a or 28e-f show dical Examiner must be nutified at	by Funeral	11. Marital Status  1 Never Married 2/20 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13. No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No		pecify Yes or No- o Rican, etc.)	14. Race · Ameri Black, White Specify: W	
2-0	72 hours netural;	eted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ntion Juring most of wor	king 16t	b. Kind of Business/Ir	ndustry
121	filed within Hygiene. other then ent, the Ma	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+) Ho	DO NOT use retired, Omemaker	)		Own hom	ne
nd 2	2 should be filed and Mental Hygid is marked other eumatic event, II	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, Mai	iden Sumame)	
ylaı	should b ind Ments marked umatic e	To	George	Ziegle				erine	Bradl	
Ma	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. item 27 is marked other then "netui		19a. Informant's Name/Relationship (7) Patricia Blackwe			-		rai Route Number, C. timore, Mi	-	p Code)
Baltimore, Maryland 21215-0036	0 0		20a. Method of Disposition  1 XBurial 2 Cremation 3 C  4 Donation 5 Other (Specify			osition (Name of matory or other place Valley	11/		c. Location - City or T Timonium,	
Balti	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licen	williar	n G. Dau 2			eonard J. Baltimore		
i	Priysician /Medical		23a. Part 1. Enter the disease, or composition of composition of the c	a. <u>CER</u>	ine. ERROVI	ter the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
ı	Examiner		Sequentially list conditions,	b and	s a consequence of):	OKE				Days.
5	ed sit	niner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence or).					7
o o	ate be executed obysician and the burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):					
8760,	cate be	dicai		d						
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ Mo 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliving Month	very Day Year
of Vital Records, P	luires that n signed b	by	Part II. Other significant conditions of	•	but not resulting in the	,	n in Part I.		cco use contribute to	
900	e law requir has been sl je 2 should l	Completed	HYPERTO	NSION	. Co	RONA	RY	24a. Was an autopsy	24b. Were aut	opsy findings available
E R		Com	ARTERY	~	EASE.			performed 1 ☐ Yes 2 ☑	d? _ death?	
Vita	sicien: Th certificate irector, pag	) Be	25. Was case referred to medical examiner?	Hospital:	ient 2 ☐ ER/Outpatie	- aCl Box   Othe		ath <i>(Check only one)</i> Iome 5 🗆 Residenc	e C □Other (Case	76 A
ion of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ation; To	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da		of 28c. Injury Work		28d. Describe how		ny)
Division	tel or Attending F is after death. el Director: After ed in by the funera	Certification;	3 Suicide 6 Could not be determined	286. Place of In	njury - At home, farm, s tc. (Specify)	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical			t of my knowledge, dea of examination and/or i tated.					
	Vith Vith Com	Σ	29b. Signature and title of certifier	1		29c. License	number 20 128 =		Date signed (Month) $1/-23-6$	
•			30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print)				
_	U		AH. GHILAD		7600 0	SLER B	r. Tou	son.	MD 21	204
	Sta Registr	_	31. Date filed (Month, Day, Year)		trar's Signature	1 . 10 .				
DH	IMH 17 Rev 1/2	40	NOV 2 7	UUI/	War All A					

The law requires that the death certificate be executed use as the burial-tran Division or Vital Records, P.O. Box 68760. physiclar signed by the a Hospital or Attending Physician: **Director:** After this certific d in by the funeral director, within 24 hours aft

To the Funeral Di

completely filled in To the

filed within 72 hours after death

al Hygiene.

Maryland 21215-0036

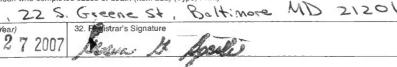
altimore,

State Registrar

DHMH 17 Rev 1/2001

Zinrin

Name and address of person who completed cause of death (Item 23a) (Type, Print)



039639

11-23-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 20 2007 **Physician** Frederick Ruppel, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Keswick Multicare Center N/A Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1**√** M 2□ F Director 215-03-2351 89 22,1918 Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 700 W. 40th Street 21211 USA Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2☐No White ð Specify: 3 ₩idowed 4 Divorced "natural". Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Percision Machinist 12 Westinghouse snould be fil. Ith and Mental Hv. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Ruppel Agnes Shalom 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Department of Health at Important: If item 27 Is any Injury or other trau Frederick Ruppel, Jr. Son 175 Wild Turkey Trail, Dahlonega Georgia 30533 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Sprial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 11/26/2007 Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Juneral Service Licenses Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic renal ears disease or condition resulting in death) /Medical Dua to (or as a consequence of): Examiner gestive Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine End-stage burial-transi pue Due to (or as a consequence of) Box 68760. attending physician certificate be Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[1/No 1 Tyes 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA this After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending P 4 hours after death. Funeral Director After t Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 🗌 Homicide within 24 hours at To the Funeral D To the Hospital 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) > or Isabelly Tac gream on 013657 November 20, 2007

Registrar
DHMH 17 Rev 1/2001

State

MISMELLE

MARGREGOR, 700 W 40th STREET, BALTIMORE, MD 21211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32, Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2

2007

Cost

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1330 1 07 ONO /Medical 4c. County of Death 4h. City. Town, or Location of Death Facility Name (If not institution, give Examiner 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Mary land Months 220.56.0345 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 Yes 2 No MD Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21223 Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 Married 1 □ Yes 2 No Specify Specify: Black ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. **7 Is marked other than "r** Elementary/Secondary (0-12) College (1-4or 5+) the Jusiness 1Each Er injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Namber, City or Town, State, Zip Code) . Informant's Name/Relationship permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Ho. MD 21223 Kobinson 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ F 4 □ Dongtion 5 □ Other (Specify) 3 Removal from State 21. Signa de o Funeral Service Licens 3alfo. MD 24216 North Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. 23a. Part1 shock Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a nonsequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 4 **☑**Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of has this certificate 2 7 N 2□No 25. Was case referred to medical examiner?
1 Yes 2 No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 OA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral I 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

AdlaN.

NOV 2

Physic /Medi Exami

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	1 - For State Registrar	(	Certifica	te of Deati	h	Reg.	No. 2007	37	621
an	1. Decedent's Name (First, Middle, Last)				2	. Date of Death	Day Year	3. Time of	
all	Edna E. Shackelford		1				24 2007	2:50	рм
er	4a. Facility Name (If not institution, give street and number			Town, or Location			4c. County of Death		
	Frederick Villa Nursing Ho	ome .ge (In yrs. last birth		onsville	er 24 Hrs 📗 g	. Date of Birth	0 Righ	imore place (State o	r Foreign
	214-07-9388 ¹□м ₂҈ <b>⊋</b> F	0 , ,	rs. Months		Min.	Month, Day, Ye July 12,	1920 Mar	yland	, oreign
	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location					10d. Inside Cit	ty Limits
ctor	Maryland n/a	Baltim	ore					1X Yes	2 □ No
<b>Funeral Director</b>	3102 Ottawa Avenue		10f. Zi	ip Code 21230			Citizen of What Cou nited Stat		
by Funer	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  2 □ Married  3 ☒ Widowed 4 □ Divorced  1 □ Yes, Give Year or Dates:	? ] No	13. Was Deco	edent of Hispanic C ecify Cuban, Mexic 2X No Specil		fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify:		
Completed by	15. Decedent's Education (Specify only highest grade completed)		Decedent's Us (Give kind of w life. DO NOT	ual Occupation ork done during muse retired)	ost of working	16b	. Kind of Business/Ir	dustry	
шо	Elementary/Secondary (0-12) College (1-4or	(5+)		Worker			anufactur	ina	
S C	17. Father's Name (First, Middle, Last)				ther's Name (/	First, Middle, Maid			
To Be	John Trice			Cl	ara Wi	lliamson			
	19a. Informant's Name/Relationship (Type. Print) Mildred L. Robinson / Niec		_				ty or Town, State, Zi e, Marylan		30
	20a. Method of Disposition	20b. Place of	Disposition (Na y, crematory or	ame of (other place)	Dat	te 200	. Location - City or T	own, State	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	e	s of Fa	ith Cem.	11/28	/07 Ro	sedale, Ma	aryland	<u>1</u>
	21. Signature) of Funeral Service Licensee	_					ral Home, ore, Mary		229
	23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	ed the death. Do no						Approximate Interval Bet	e ween
	Immediate Cause (Final disease or condition	Hage Alz	holina	r Dam	antia			Onset and I	Death
	resulting in death)  Due to (or a	s a consequence o	f):			-			
<u>_</u>	Sequentially list conditions, bb.	s a consequence o	£).						
Medical Examiner	cause. Enter Underlying Cause (Disease or injury	s a consequence o	1).						
xan	that initiated events C.	s a consequence o	f):						
ä	L <sub>a</sub>								
edic	d.								
Physician/M	In the past 12 injentins?	e pf pregnancy 2 ☐ Fetal death at time of death	3□Ectopic 5□ Other (s				23d. Date of deliv		Year
ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown								
by Pi	Part II. Other significant conditions contributing to death	but not resulting in	the underlying	cause given in Par	rt I.	23e. Did tobac	co use contribute to		leath?
etec						24a. Was an	24b. Were aut	oney findings	available
Completed by						autopsy performed 1 Yes 2	prior to co	ompletion of c	ause of
Be	25. Was case referred to medical examiner?			26. Pla	ace of Death (	Check only one)			
70	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpat		_		Nursing Home	e 5 🗆 Residenc	e 6 □Other (Spec	ify)	
on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, D		njury	28c. Injury at Work?		d. Describe how i	njury occurred		
cati	2 Accident Investigation 3 Suicide 6 Could not be	njury - At home, far	M etreet facto	1 ☐ Yes 2		of Location (Street	t and Number or Ru	m/ Pouto Nun	phor
ertifi		etc. (Specify)	III, Street, Iacit	ny, onice	20	City or Town, S	taria Number or Hull Itate)	al noute Ivuii	iber,
Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the bess 2 Medical Examiner: On the basis and manners	of examination and	, death occurre d/or investigation	d at the time, date on, in my opinion, o	and place, and death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s	s)
Me	29b. Signature and title of certific			9c. License numbe			Date signed (Month		
	I Debrahd frene Do	=		H4593	1	Λ	lovember	2614	2007
	- Fig.	death (Item 23a) (7 2835 Sh	Type, Print) nith A	venus	Suite	6203	lovombor Baltımcı	3,MD	21209
ate rar	31. Date filed (Month, Day, Year) 92. Regis	strar's Signature	Develo						1

			Plea						. Ensure A			_	
		For State		State	of Ma	arylan	•	artment of I rtificate of	Health and N	Mental Hy	_	000	07600
× =	0.1	Registrar  1. Decedent's Name	ie (First, Middle	e, Last)			Cei	lilicate of	Dealli	2. Date of D	Reg. No.	2001	3 6 2 2
Physici /Medic		Eugenia				:	Sollon			Month Novemb	er 2	6, 2007	. 20
Examir		4a. Facility Name (I							or Location of Death			County of Dea	
Funeral	<u> </u>	505 South 5. Social Security N		e Street 6. Sex		e (In yrs. I	last birthday)	If Under 1 Year	altimore  If Under 24 Hrs.	N/A  8. Date of Birth  9. Birthplace (St.			thplace (State or Foreign
Director	П	217-40-63		1 □ M 2 <b>X</b> F		64	1 Yrs.	Months Days	Hours Min.	(Month, D May 18		C	ountry) ryland
land bw ft		Usual Residence of 10a. State	f Decedent 10b. County			10c. City	, Town or Lo	cation					10d. Inside City Limits
a-f sho	ctor	Maryland	N.	/A			Baltin	more					1 X Yes 2 □ No
or 28 be not	Funeral Director	10e. Street and Nur						10f. Zip Code	_		10g. Citi	zen of What C	ountry?
eath v 1s 23a must	eral	505 South	Savage	e Street	ecedent l	Ever in U.	S 13 1	21224		pecify Ves or N		JSA 14. Race - Am	erican Indian.
after d or iten miner		1 Never Marr	ried 2 Marr	Armed	Forces?			if Yes, specify Cub 1 ☐ Yes 2 🛣 No	Hispanic Origin? (Sp ban, Mexican, Puerlo Specify:	Rican, etc.)		Black, Whi	
hours ural",	d by	3 Widowed		Year o	r Dates:								hite
iin 72 i n "nat Medica	plete			st grade complete			16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	king	16b. Ki	nd of Business	/Industry
ed with /giene er tha t, the I	Completed	12 years			e (1-4or 5	1+)	Seci	retary			Bal	timore	City
I be file ntal Hy ed oth	a	17. Father's Name of Steven Ja		,					18. Mother's Nam			Surname)	
should nd Me mark mark	2	19a. Informant's Na					19b. Mailir	ng Address (Street	and Number or Ru			r Town, State,	Zip Code)
and 2 salth a n 27 Is	. 4	James Sol	.lon	Brot	her		6724	Gracelar	nd Avenue	_Balti	more,	Maryla	nd 21224
iges 1 nt of Hi if Iter			Cremation	3 □Removal fro	m State	C	lace of Dispo emetery, crer	sition (Name of natory or other pla	Nover	nber	20c. Lo	cation - City or	Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation  21. Signature of Fa	-7			Cak		Cemetery  Name and Addre		2007		dalk,Man	
Dep Per Sundany		K	Som	R	7		Cc	onnelly F 110 Solle	uneral Hoers Point	ome Of I Road, I	Dunda Dunda	lk,P.A.	21222
Variation of the		23a. Pan Inter the shock, or hea	he disease, or art failure. List	only one cause of	n each Iir	ie.	. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
Physician /Medical		Immediate Cause ( disease or condition resulting in death)	(Final in	a		LONF		ARTER	Y DIS	EASE	<u> </u>		Onset and Death
Examiner					to (or as	A B	ience of):	MEI	LLTUS				
₽ #	iner	Sequentially list con if any, leading to im cause. Enter Unde Cause (Disease or	nditions, nmediate erlying	b. Due	to (or as	a consequ							-
oe executed cian and ourial-transit	Examiner	Cause (Disease or that initiated events resulting in death) L	S	C. Due	to (or as:	a Danšinali	uince offi						
cate be e: physician the buria													
ntificate bong physicies as the bu	Physician/Medica	IF FEMALE:											
eath certific attending pl	ian/	23b. Was decedent in the past 12	months?		e birth	2 Fetal	death 3	Ectopic pregnanc	y		2	23d. Date of de Month	livery Day Year
the de	ysic	1 ☐ Yes 2 ☑ 9 ☐ Unknown		9□Un		time of de	eath 5L	Other (specify) _					
The law requires that the death certificate be ate has been signed by the attending physicia page 2 should be detached for use as the bur	by Pi	Part II. Other signif	ficant condition	ons contributing to	death bu	ut not resu	Iting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	se contribute to	o the cause of death?
requir een si hould I										10	Yes 2[	Mo 3∏P	robably 4 □Unknown
sician: The law certificate has birector, page 2 s	Completed									24a. Was auto perf			utopsy findings available completion of cause of
	a	25. Was case refer	red to medical						26. Place of Dea	1□ Yes	2 <b>12</b> No	1 ☐ Yes	s 2□ No
hysici this ce al direc	To B	examiner? 1 ☐ Yes 2 ☑			☐ Inpatie		ER/Outpatien		ner: 4 ☐ Nursing He		-	6 □Other (Spe	ecify)
ding F After funera	tion:	27. Manner of Deatl	th 5 ∐Pending investig	g <i>(M</i>	te of Injui onth, Day	ry / Year)	28b. Time of Injury	Wor	ryat rk?  Yes 2 □ No	28d. Describe	how injur	y occurred	
Atten er deat ector: by the	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n	not bo	ice of inju	iry - At hoi	me, farm, str	eet, factory, office	1.00 2 0,10	28f. Location (	Street and	d Number or R	ural Route Number,
urs after or ral Dir											wn, State,		
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, is	Medical	29a. Certifier (Check only one)	1 Certifyin 2 Medical	Examiner: On the	the best of basis of anner sta	examinat	wledge, death tion and/or in	vestigation, in my	me, date and place opinion, death occu	, and due to the rred at the time	cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)
To with	Σ	29b. Signature and	title of certifier	A M	D			29c. Licens	060027			e signed (Mon. EMBER	th, Day, Year) 26 2007
, }		30. Name and addre	ess of person	who completed ca	use of de	eath (Item	23a) (Type,	Print) A A					NP 21224
Sta Registr		31. Date filed (Month		2007	Registra	ar's Signat		alls				•	
		1 4	IOK W 6	200	4. 11/4		1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #8, perFH,g873, 11/27/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Olive Virginia Stifler bucmbey 21, 2007 4c. County of Death 9:10 AM /Medical 4a. Façility Name (If not institution, give street and number City, Town, or Location of Death Examiner HavredeGrace 49r sond Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1928 1 □ M 2 💢 F Days Hours Min. 235-44-5006 79 Director 11/15/<del>2007</del> Virginia West Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at Harford Pylesville MD Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 4416 Graceton Road 21132 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No Specify. White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Blue Bell Waitress 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Omar Kellison Florence M. McLaughlin ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 8 Pylesville, MD. 21132 James T. Stifler, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 11/26/07 Goodwill Cemetery Fallston, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 3 Newport Drive Forest Hill, MD. 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 3 ☑ No performe director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes No Other: 2 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many of stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

(Month, Day, Year) NOV 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2007

**ORIGINAL** 

		4	- Statemend #10g per	State of Maryland FH G873 11/28	d/Depa	rtmen tificate	of Head	alth and M eath	1ental Hyg เ	giene Reg. No2 () (	37624	4
	Dhysisis		Decedent's Name (First, Middle, Last)		-				2. Date of Dea Month	ath	3. Time of Death	
	Physicia /Medic	al	Paola Serruto	and mumbers		4h City	Town or Lo	ocation of Death	Novemb	er 21, 2	2007 5:50 P.	
	Examin	er	4a. Facility Name (If not institution, give str Stella Maris Nursir				nium	cation of Death		Balti		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I			1 Year   I	f Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h	Birthplace (State or Foreign Country)	n
	Director		212-56-9042	M 3/5/F   8	35 Yrs.				3/31/	1922 I	lusa, Italy	
	land bw		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits	,
	Mary a-f sh ified a	io	Maryland Baltimon	re I	utherv	ville					1 ☐ Yes 2 ☐ No	_
	or 28	Director	10e. Street and Number			10f. Zip		22		10g. Citizen of W	States	
	sath w	Funeral	1432 Burton Avenu	JC 2. Was Decedent Ever in U.	S. 13. V	Was Dece	2109 lent of Hisp	anic Origin? (Sp	ecify Yes or No	14. Race	- American Indian,	$\dashv$
320	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		lfYes,spe⊲ 1⊡Yes	cify Cuban,	Mexican, Puerto Specify:	Rican, etc.)	Black	white, etc. White	
2-003p	72 hou natura lical E		15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Deced	kind of wo.	rk done dur	on ring most of work	king	16b. Kind of Bus	siness/Industry	
Ž	vithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>po not u</i> s seamst				Fashion	n Garments	
7 0	filed w Hygie other t		17. Father's Name (First, Middle, Last)			Cano		8. Mother's Nam	ne (First, Middle,	Maiden Surname		
yland	lid be fental rked o	To Be	Antonio Zito					Antoni	na Mice	li		
Mary	2 shou and N Is ma auma		19a. Informant's Name/Relationship (Type	•						er, City or Town, S		
e, ≥	1 and Health He 27 Iher tr		Toni Serruto/ daug	20h F	Place of Dispo	sition (Na	ne of	1	Date	lle, Mar	Cyland 21093 City or Town, State	$\dashv$
0	ages ant of h t: If lite y or of		1 Donation 5 ☐ Other (Specify)	emoval from State Dul	emetery, crei aney V	matory or o	ther place)	Nove	ember 2007	Timoniu	ım, Maryland	
Saltimor	mit. Poartme		21. Signature of Foreral Service License	• /// IMen	orial Pé	Garde 2. Name ar Pacefi	⊇ns nd-Address 1				emation Ctr.,P land 21093	, A
מ	Depar Impor any ir		14/10:13	Mh		232	Yor!	k Road	Timoniu	ın, Maryl		
			23a. Part   Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deat e cause on each line.	h. Do not ent	ter the mod	le of dying,	such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ALZHEIMERS  Due to (or as a consequence)	uence of):	_		-				
	Examiner		Sequentially list conditions b.									
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseq	uence of):							
	execut and al-tran	xan	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							
8/60	death certificate be executed e attending physician and d for use as the burial-transit	dical I	<b>€</b> d.									
Õ	ertifica ing ph e as th	Med	IF FEMALE:	2. If we subseme of more		-				00.4.5-4		
X R R	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3	□Ectopic p □ Other (s				Mor	te of delivery nth Day Year	
o.	at the de by the a	hysi	1 ☐ Yes 2 📉 No 9 ☐ Unknown	9□Unknown								
JS, P.	The law requires that the tte has been signed by this age 2 should be detache	þ	Part II. Other significant conditions conf	tributing to death but not res	sulting in the u	ınderlying	cause given	ı in Part I.			ribute to the cause of death?  3 Probably 4 Unknow	√П
Ö	v requi	eted							24a. Was	an 24b. \	Were autopsy findings availab	le
Ř	h <b>ysician:</b> The law his certificate has t I director, page 2 s	Completed							auto perfe 1□ Yes	ormed?	prior to completion of cause of death? 1 □Yes 2□ No	
ta		Be C	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only			_
7	Physic this ceral dire	၉	1 ☐ Yes 2 <b>X</b> No H	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie			4 Nursing F		idence 6 Other		
on (	ding h. After funes	tion:	1 X Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M	28c. Injury Work? 1 ⊟ Y	es 2 □ No	200. 20001120	now many cood		
Division or Vital Records,	I or Attend after death Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, st	reet, factor	y, office			(Street and Numb wn, State)	per or Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical C	29a. Certifier 1 CertifyIng Phys (Check only one) 2 Medical Examir	sician: To the best of my knowner: On the basis of examinand manner stated.	owledge, dea ation and/or i	th occurred	at the time	e, date and place inion, death occi	e, and due to the urred at the time	e cause(s) and ma , date and place,	anner as stated. and due to the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certifie			29	c. License			29d. Date signe	d (Month, Day, Year)	
)	1		1./-,				194	3725			123/67	
3			30. Name and address of person who co				רייף (	LMONIUM,	MD 210	93		
	St	ate	DR. TARIQ MAHMOOD  31. Date filed (Month, Day, Year)	2300 DULANE Registrar's Sign		EI KL	,. IJ	LTON LUFT	FW 210	,,		
	Regist		NOV 2. 7 200		K Bo	BARLS						

NOVEMBER 21, 2007 6:00 p.m.

PAOLA SERRUTO

Physician
/Medical
Examiner

1 Decedent's Name (First Middle Last) Marie S. Smith

OVEMBER (92007

4a. Facility Name (If not institution, give street and number) Genesis-Loch Raven

4b. City, Town, or Location of Death Parkville

4c. County of Death

**Funeral** 

5. Social Security Number 1 □ M 2**X** F

If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Days Yrs

Baltimore 8. Date of Birth (Month, Day, Year)

Director

f Heelth and Mental Hygiene. Item 27 is marked other than "naturel", or Iteme 23e or 28e-f ehow other traumatic event, the Medical Examinar must be notified at

ပ

Examine

Physician/Medical

Completed by

To Be

Certification:

Medical

filed within 72 hours after

Pages 1 and 2 should be intentional to the little and Mental I intentional tentions.

= 5

permit. Page Department of Important: If eny injury or once.

Maryland 21215-0036

Baltimore,

218-28-2641 Usual Residence of Decedent 10a. State 10b. County

10c. City, Town or Location

77

Hours

Birthplace (State or Foreign Country)
 Maryland

death with the Maryland

MD

Baltimore

Parkville

10d. Inside City Limits 1 Yes 2 No

Be Completed by Funeral Director 10e. Street and Number

3008 California Avenue

10f. Zip Code 21234 10g. Citizen of What Country? USA

1 Never Married 2 Married

12. Was Decedent Ever in U.S. Armed Forces?

College (1-4or 5+)

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc.

3 Widowed 4 Divorced

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 ☐ Yes 2 X No Specify:

White

Elementary/Secondary (0-12)

10

16b. Kind of Business/Industry Bendix

Specify.

17. Father's Name (First, Middle, Last)

Assembler

Vernon Smith

18. Mother's Name (First, Middle, Maiden Sumame) Mary Hallameyer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print)

Anna Cornett-sister

3008 California Avenue-Parkville, Maryland 21234 20b. Place of Disposition (Name of 20c. Location - City or Town, State

20a. Method of Disposition 

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

cometery, crematory or other place)
Moreland, Memorial
Park 22. Name and Address of Facility
EVANS FUNERAL CHAPEL AND CREMATION SERVICES

Nov.24,2007 Parkville, Maryland 8800 Harford Road Parkville,MD 21234

**Physician** /Medical Examiner

nding physicien end use as the burial-transit

ettending physic for use as the b

been signed by the should be deteched

page 2

To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, p.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each-line.

Due to (or as a consequence of) tructive pul monarma sease

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 2 Fetal death 4☐Pregnant at time of death

9□ Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autonsy perform 1□ Yes 2/2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 20 No

25. Was case referred to medical examiner? Hospital: 1 | Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA

26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident

3 🗌 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28I. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

NOV 2

SIEICHN

29c. License number 3 64

31. Date filed (Month, Day, Year)

32 Registrar's Signature

ЛЛО

completed cause of death (Item 23a) (Type, Print)

70

State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	-	partment of F ertificate of			ene g. No. 2 N N 7	37626
	Dhusisi	ži.	1. Decedent's Name (First, Middle,	,				2. Date of Death	2001	3. Time of Death
	Physicia /Medic	_	Eugenia Lee Scot					November	20,2007	7:00 A.M
	Examin	er	4a. Facility Name (If not institution, g				r Location of Death		4c. County of Death	
	Funeral		1724A Hilltop Av 5. Social Security Number 6		(In yrs. last birthda		If Under 24 Hrs.	8. Date of Birth	Baltimore	nplace (State or Foreign
Ь	Director		212-36-9153	1 □ M 2 🛣 F	68 Yrs.	Months Days	Hours Min.	(Month, Day, August 3	1,1939 Oli	ve Hill, Ky.
	w w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryll-f sho	tor	Maryland Baltin	ore County	Essex					1 ☐ Yes 2 🗷 No
	th the or 28a e noti	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	untry?
	ath wi	ral	1724A Hilltop Av				1221		United St	
920	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	o I	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)	14. Race - Amer Black, White Specify: W	
50	72 ho 'natur dical I	eted	15. Decedent's (Specify only highest	Education grade completed)	i (G	cedent's Usual Occup ive kind of work done	during most of work	king [	6b. Kind of Business/I	ndustry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) life	e. DO NOT use retired Social W	•		Social W	ork
d 2	filed Hygie		17. Father's Name (First, Middle, La			SOCIAL W		e (First, Middle, M		OLK
'lan	should be nd Mental marked o Imatic eve	To Be	Orville Eugene S	cott			Marjorie	M. Craw	ford	
Maryland	2 should the and Ment is marked aumatice		19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	ailing Address (Street	and Number or Rui	ral Route Number,	City or Town, State, Z	ip Code)
	47 ± 6		Mr. Philip G. So	ott (Brothe		L Locust A		sex, Mar	yland 21	221
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition  1  Burial 2  Cremation 3  4 Donation 5  Other (Spe	cify)	Dulaney	sposition (Name of trematory or other place Valley Me	m. Nov.2	24,2007	Timonium,	Maryland
Ba	permit Depar Impor any Ir		21. Signature Funeral Service Lie	ensee - gav	rife.	Peaceful A	lternativ Road	es Funer	al&Cremati	on Ctr.,P.A. 21093
171	Physician /Medical		23a. Party. Enter the disease, or or studek, or pear failure. List or Immediate Cause (Final disease or condition resulting in death)	implications that caused ally one cause on each line	the death. Do not e.	enter the mode of dyli	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death Man Fu S
	Examiner		On a second to the desired state of	b Due to (or as a	o ma quence on.					
	ed sit	iner	Sequentially list conditions, if any, leading to immediate unues. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):					
	tificate be executed ig physician and as the burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as ε	a consequence of):					
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	rtificat ng phy as th		IF FCMALC.							
.0. Box	that the death certifi ed by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deli Month	very Day Year
ds, P.	w requires that the deben signed by the should be detached	þ	Part II. Other significant condition	contributing to death bu	t not resulting in the	e underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to s 2 □ No 3 □ Pro	
Records	w requ	letec						24a. Was an		topsy findings available
Re	The law ate has b page 2 sh	ompleted						autopsy perform	prior to c death?	completion of cause of 2 No
or Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only one		2 110
)r V	dis ys	To E	1 □ Yes 2 No		nt 2 ER/Outpat		4 ☐ Nursing H	ome 5 Resider	nce 6 □Other (Spec	cify)
ou c	ding Ph h. After th funeral	ion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day		y Wor	ryat nk? Yes 2 ∐No	28d. Describe how	w injury occurred	
Division	Attending r death. ector: After	ficat	3 Suicide 6 Could no	he l	ry - At home, farm,	street, factory, office	163 2 110	28f. Location (Str.	eet and Number or Ru	iral Route Number,
ă	tal or s after ai Dire	Certification:	4 ☐ Homicide determine	building, etc	. (Ѕреспу)			City or Town,	, State)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 CertifyIng 2 Medical Ex	Physician: To the best o caminer: On the basis of and manner stat	examination and/o	eath occurred at the ti r investigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the l	Me	29b. Signature and title of certifler	elatert 1	1 m	29c. Licens	e number	29	od. Date signed (Month	n, Day, Year)
•	47		30, Name and address of person w			pe, Print)	10	2 6		1. MD. 21237
			31. Date filed (Month, Day, Year)	Water+ e	c/d 9/0.	3 Frank	lindg.	D1.5+2	200 Dalto	1. MD. 21237
	Sta Registr			2007 Bours	y 910.	parke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** h ROEllel 0 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner OAK CREST VILLAGE CARE CENTER Parkville Baltimore County Birthplace (State or Foreign Country) Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. 8. Date of Birth (Month, Day, May 29, 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** Months 1**₩** 2□F 92 1915 Maryland A214-01-4275 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Baltimore County Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 8834 Walther Blvd. **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No altimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Conductor Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Justis Henry Schroeder Olive Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trau (Son) Richard M. Schroeder 1077 Lyndale Drive, Westerville, OH 43081 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Wesley Freedom U. Meth Cem 11/27/07 Eldersburg, MD 21. Signal of Tymeral sended igensee MITCHELL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? ntributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Completed by 1 Yes 2 No 3 Probably 4 Whitnown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 24 To the F 29d. Date signed (Month, Day, Year) 29c Nicense number 29b. Signature and title of pertifie 23a) (Type, Print) 30. Name and address of person who completed cause of death 3 MUCE

DHMH 17 Rev 1/2001

State

Registrar

Day, Year)

31. Date filed (Month,

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32. Fegistrar's Signature

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: completely

> State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only

29b. Signature and title of ce

31. Date filed (Month, Day, Year)

Registrar's Signature

of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

BaltonDDDO

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death Day Physician Rose J. Svec 6::30 AM November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Nusing Center Dundalk Baltimore Co. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1 M 2 3 F Director 93 215-01-8701 March 17,1914 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at be notified 1 ☐ Yes 2 XNo Director Maryland Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 items 23a 2469 Fairway 21222 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 1 ☐ Yes 2⊠ No Specify Specify: þ White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, it once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Kolar ပ Josephine Dusek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Detzel (Daughter) Dundalk, Maryland 21222 2467 Fairway 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 14 Burial 2 □ Cremation 3 □ Removal from State □Donation 5 □ Other (Specify) Most Holy Redeemer Cem 11/26/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7022 Wise Ave. Dundalk, Maryland 21222 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner

attending physician and for use as the burial-trar been signed by should be detac

Baltimore, Maryland 21215-0036

within 24 hours area within 24 hours area To the Funeral Director: Aff

Hospital or Attending Physician: The law requires that the death certificate be executed

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Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobaccouse contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Dres 2 No 3 Probably 4 □Unknown 24b Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 LNO 2 ER/Outpatient 3 DOA ၉ 1 🔲 Inpatient 27. Manney Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Matural 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be. 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) detern 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month

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who completed cause of death (New 233) Type, Print

2007

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTTM 28a per PHYS C873 11 (27/07 WS State of Maryland Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day Year **Physician** Louis Slawski Arthur November 20, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7409 Alvah Avenue Baltimore Co. Dundalk Apt. G Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Months Hours 1**X** M 2 □ F Yrs 82 Dec. 26,1924 Maryland 218-14-7863 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🖾 No Director **Dundalk** Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 "natural", or items 23a 7409 Alvah Ave. Apt. G United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★DX'es 2☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2001No Maryland 21215-0036 Specify Specify: ğ 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Crown Cork & permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Seal Corp. Assembly 9 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Lukowski Slawski ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 28147 (Son) 427 Willow Road Salisbury, NC Adam Slawski altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from Stat Baltimore National Cem. 11/26/2007 Baltimore, MD 4 ☐ Donation 5 Other (Specify) 21. Sign Jure of Funeral Service to 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebicvascular **Physician** /Medical Due to (or as a consequence of): Examiner Myocard Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit trial and Due to (or as a consequence of): Box 68760, attending physician for use as the buria ortic Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. | been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 3 Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate or Attending Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending s after death.

I Director: Af
id in by the ful 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated.

641

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

#

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

32. Registrar's Signature

Easto

29c. License number

29d. Date signed (Month, Day, Year)

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### Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.

Jason Thomas Short State of Maryland / Department of Health and Mental Hygiene  1-For State Certificate of Death Pearly 2007 375										7 0760			
Physicia		Registrar 1. Decedent's Name (First, Middle,L	ast)	Cer	tilicate of	Death			2	Re Date of Death	g. No.	11/2	Time of Death
Medical Exami	ner		Jason		omas	Short		<del></del>		<sub>Month</sub> November	Day Year 18, 2007		2208 hrs
*		4a. Facility Name (if not institution, Wise Avenue & Bumhar		oer)		b. City, Town, Dundalk	, or Lo	ocation of L	Jeath		4c. County of E Baltimore		tv
Funeral				Age (In yrs. I	ast birthday)	If Under 1 Y	rear	If Under 2	24Hrs.	8. Date of Birt	h(MM/DD/YYYY)		
Director		213-06-1323	XM 2 F	28	Yrs	Months [	Days	Hours	Min.			oreign	maryland
	ŀ	Usual Residence of Decedent	Δ	20		1		L		000.	10,1373		" Hary rana
v any	ſ	10a. State 10b. County		10c. City,	Town or Locati	on							0d. Inside City Limits
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fler de		3 Widowed 4 Divorce	1 Yes ed If Yes, Give Year	2 X No	1	Yes 2 X	No	specify:			Specify:	W	hite
ours a atura	d b	15. Decedent's Education (Specify	only highest grade	completed)	16a. Deceden	's Usual Occu	upatio	n (Give kin	d of wo	rk done	16b. Kind of Busin		
16 n 72 h an "n ical E	Completed by	Elementary/Secondary (0-12)	College (1-4		,		ille. L	JO NOT US	e reure	a)	Chesape Residen		
OO3	E	17. Father's Name (First, Middle, La	2 Year	rs	Rea	ltor	110	Mathoric	Nomo /F	First Middle N	Residen  Maiden Surname)	Lla	1.
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	BeC	George A. Show	,				"			e M. Ar			
21; ould b d Men s mar lic eve	P	19a. Informant's Name/Relationship	(Type, Print)	-							ber, City or Town,		
MD nd 2 sh nd 2 sh alth an m 27 i		Mrs. Janice M.	Short (Mo								od, Maryl		
Ore, es l ar of Hez If ite		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from	State	Place of Dispos crematory or oth	er place)				Date	20c. Location - C	•	
Lime Page timent trant:		4 Denation 5 Other Spec	ify:	0;	ak Lawn				1/2	1/2007	Baltimo	re,	Maryland
Bal permii Depar Impo		21. Signature of Funeral Service Lic	censee	9	22. N	ame and Add	ress o	of Facility Funer	al I	Home of	Dundalk Maryland	, I	nc.
Physician	4	23a. Part I. Enjer the disease, or co	mplications that cau	sed the death	. Do not enter the	22 Wis ne mode of dy	e I	Ave. uch as card	Dur diac or r	espiratory arre	est, shock, or heart	21.	Approximate Interval
/Medical taminer		failure List only one cause on Immediate Cause (Final disease	each line. a. Multiple Injur	ies									Between Onset and Death
, vanniner		or condition resulting in death)	Due to (or as a co	onsequence o	of):								
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60, e be executed ysician and burial - transit	edical	UNPENDED	AMENDED		-								
876( ificate ig phys		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, ou			tal death	3	Ectopic p	reanana	~	23d. Date of de Month	livery Da	ay Year
Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	past 12 months?	4 Pregnar	t at time of de	aath	ner (Specify)	J _	ctopic p	n egnan	-y	Wichti	De	ay Icai
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Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Inc	atient 2	ER/Outpatient			of Death (Cother			Residence 6	Other:	Scene
of Vi ing Physi After this uneral dir	유	1 ✓ Yes 2 No 27. Manner of Death	28a Date of	Initury	28b. Time of I		Injury	at Work?	2	8d. Describe	now injury occurred		
Sion Attendir death. ctor: A	atio	1 Natural 5 Pending 2 Accident Investig			FOUND: 2208 hrs	1	Ye	es 2 🗸 N	6 P	assenger a	auto fixed obje	ct co	llision
Division of Vital Records, rat or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the	Certification:	3 Suicide 6 Could r	28e. Place o		ome, farm, stree	et, factory, offi	ce bui	ilding, etc.	2	8f. Location (S	Street and Number tate)	or Rur	al Route Number, City
D ospital hours interal		4 Homicide determine 29a. Certifier 1 Certifying Physics	(0,000,1)/	Local Stre			_				tate) & Bumham Roa		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only	sician: To the best oner:On the basis of and manner state	examination a	-								
F 2 F 8	₽	29b. Signature and title of certifier	Grid Highlier Sta			29c. Lic	ense	number			29d. Date signed	(Mon	th, Day, Year)
		Harrath & MILLY	ull mo			0.	.C.M	I.E.			November 1	9, 20	07
10		30. Name and address of person with	-			1 Donn Ct	'00t	Raltim -	ro Mar	21204			
2	ate	Pamela E. Southall, MD 31. Date filed (Month, Day, Year)		edicai Exa strar's Signat		1 Penn Str	ન્દા,	Daluliio	ne, Wil	J Z 1ZU 1			
Regist		110110 m a	007 /	a A	loor.	20							

07-08978 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene James Shoul 1- For State Certificate of Death Registra 2. Date of Death 1. Decedent's Name (First, Middle,Last) James Francis Shoul, Jr. Physician/ Month Day November 20, 2007 1130 hrs Medical Examiner James Francis Shoul, Jr. 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** N/A Sinai Hospital If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Director 1956 Marry land Feb. 6, 1X M 2 F 215-68-4830 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1XX Yes 2 No Baltimore Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Titem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatie event, the Medical Examiner must be notified at once. Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21211 3633 Keystone Avenue Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces 1 Never Married Married 1 X Yes Specify: White If Yes, Give Year 4 X Divorced Yes 2 XX No specify: 3 Widowed ş 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Shipping Container Elementary/Secondary (0-12) College (1-4 or 5+ Iron Worker MD 21215-0036 Industry 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mable Canapp Be James Francis Shoul, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3633 Keystone Avenue Baltimore, MD 21211 Mother Mable Otten 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dorsey, Maryland 11/26/2007 Department of Meadowridge Memorial Other Specify Donation 5 21. Signature of Fureral Service Licensee

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home,

3631 Falls Road Baltimore Mary

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Death "Medical Hypertensive atheroscleotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit sician/Medical ttending physician ar r use as the burial - to X AMENDED #1,23a,27,permE,g874, 12/27/07 TT X UNPENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yes 2 No 3 Probably 4 V Unknown è Completed 24b. Were autopsy findings available Records. 24a. Was an prior to completion of cause of autopsy this certificate has performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Vital Be Other<sub>4</sub> examiner? Hospital: 1 ✓ Inpatient 2 Nursing Home 5 Residence 6 DOA ER/Outpatient 3 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a, Date of Injury (Month, Day, Year) 28b. Time of Injury ಕ 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Division Pending the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide or Town, State) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 21, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 3. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007 Registrar OCME **ORIGINAL** DHMH 17 Rev 1/2001

	For	State of Maryland / Department of Health and M	Mental Hygiene UU/	3/63
-	State Registrar	Certificate of Death	Reg. No.	
. D	ecedent's Name (First, Middle, Last)		2. Date of Death  Month Day Year	3. Time of Death

Physician /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be tited within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show amy injury or other traumatic event, the Medical Exeminar most by Italia at once.

Physician /Medical

Baltimore, Maryland 21215-0036

Examiner ed by the ettending physician and detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires thet the death certificate be executed within 24 hours atter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit D

an al	Camilla Skrovane	k								14:57 <sup>M</sup>				
er	4a. Facility Name (If not institution, give	a street and num	ber)		4b. City,	Town, or	Location	of Death	4c. County of Death					
	Suburban Hospita	.1				ethe:					Mont	gome	ry	
	Social Security Number     6. S	Sex 7 □M 2537F	7. Age (In yrs. I		If Unde Months	r 1 Year Days	If Unde Hours	Min.	8. Date of (Month,	Day, Year	)	Coun		
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	Usual Residence of Decedent  10a, State 10b, County		10c City	, Town or Lo	cation							1	0d. Inside City Limits	
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Sct	Maryland Montgo	omery	I	Betheso										
Dire	10e. Street and Number				10f. Zij	p Code				10g. C	itizen of Wh	at Coun	try?	
Be Completed by Funeral Director	9910 Carnegie Te	rrace				0817					ited :			
Ine	11. Marital Status	12. Was Deced		S. 13. \	Was Dece f Yes, spe	dent of H orfy Cuba	ispanic O In, Mexica	rigin? (Sp ın, Puerto	ecify Yes or Rican, etc.)	No-	14. Race - Black,	White,		
ΥF	1 ☐ Never Married 2 ☒ Married	1 Tes, Give	9		1 🗆 Yes	2 <b>7</b> No	Specify	<i>'</i> :			Specify:	Wh	ite	
d b	3 Widowed 4 Divorced	Year or Da	tes:											
ete	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	kind of wo	ork done	durina mo	st of worl	king	16b.	Kind of Busi	iness/Ind	dustry	
ldπ	Elementary/Secondary (0-12)	College (1-			DO NOT L									
ပ္ပ	12			Produc	tion	Lin							onics	
Be	17. Father's Name (First, Middle, Last,	1					18. Moth	ier's Nam	ne (First, Mid	dle, Maide	n Sumame)	)		
ပ္	Ernest Gruner						F	lelen	a Schi	ank				
ļ	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Addres	s (Street	and Numb	er or Ru	ral Route Nu	mber, City	or Town, S	tate, Zip	Code)	
	Ambroz Skrovanek	: / Husba	and	9910	Carne	gie	Terr	ace,	Bethe	sda,	MD 20	817		
	20a. Method of Disposition		20b. P	lace of Dispo	sition (Na	me of other plac	(e)	Morre	Date mber 2	6 20c. I	ocation - C	ity or To	wn, State	
	t  ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	-	State Park	emetery, crer cLawn 1 Par	Memor	ial	1	NOVE	2007		kw1114	о M	aryland	
	21. Signature of Funeral Service Licer	• •				nd Addre	ss of Faci	ity Rob	ert A.	Pum	phrev	Fun	eral Home/	
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	23a. Part1. Enter the disease or com- shock, or heart failure. Vist only	plications that ca											Approximate	
	Immediate Cause (Final												Interval Between Onset and Death	
	disease or condition resulting in death)	~ · · · · · · · · · · · · · · · · · · ·	ute Cor		Synd	rome						_		
			or as a consequ											
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nin	cause. Enter Underlying Cause (Disease or injury													
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sician/Medicai Examiner		_ d.												
/Me	IF FEMALE:	23c. If yes, outo	come of pregna	DCV							22   5 .	4.1.1		
ian	23b. Was decedent pregnant in the past 12 months?	1□Live bi	rth 2 Feta	death 3	Ectopic		1				23d. Date Mont		ory Day Year	
/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∟Pregna 9□Unkno	ant at time of down	eatn 5L	Other (s	респу)								
Completed by Phy	Part II. Other significant conditions	contributing to de	ath but not rose	ulting in the u	ndorhina	021100 000	on in Pad	. 1	230 0	id tobacco	use contrib	oute to th	ne cause of death?	
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a	25. Was case referred to medical						26. Pla	ce of Dea	th (Check or	ily one)				
To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 🗆 Ir	npatient 2K	ER/Outpatier	nt 3 D	OA Oth	er: 4 □ N	lursing H	ome 5□R	esidence	6 □Other	(Specif	v)	
2	27. Manner of Death	28a. Date o	of Injury h, Day Year)	28b. Time o	f	28c. Injur Wor	y at		28d. Descri	be how in	ury occurre	d		
atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio		ii, Day 16ai)	Injury	М		Yes 2[	□No						
ific	3 Suicide 6 Could not be determined	28e. Place	of Injury - At ho		reet, facto	ry, office						r or Rura	al Route Number,	
Certification:	4   Hollsicide	buildin	ng, etc. (Specif	γ)					City or	Town, Sta	110)			
aic					death occurred at the time, date and place, and due to the causel						e(s) and manner as stated.			
Medicai			asis of examina		or investigation, in my opinion, death occurred at the time,									
Me	29b. Signature and title of certifier	11	^		29c. License number					29d. C	29d. Date signed (Month, Day, Year)			
	1 Anim	2 13	Me		D0052832 No					November 23, 2007				
	30. Name and address of person who	completed caus	e of death filten	n 23a) (Tvna	Print)	20,				1,5			, 2007	
				, \ \ , \ Pu',										

State Registrar

Bobrava-Sherman, M.D.

31. Date filed (Month,

32. Registrar's Signature

1396 Piccard Drive, Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #17, perFH, g873, 11/29/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Day 21, 2007 6:10 A M Physician John Basil Saratsiotis /Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 902 Crestwick Rd. Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 5/15/1915 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 X M 2 □ F Greece 218-44-8010 92 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State r 28a-f show notified at MD 1 ☐ Yes 2 XNo Baltimore Towson Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 21286 902 Crestwick Rd. USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married White 1 ☐ Yes 2 ☐ XNo Specify: Saltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Physician 2 should be filed v and Mental Hygie is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vasilios Saratsiotis Be Aphrodite Economides Seretciatis P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is n any injury or other traun 902 Crestwick Road 21286 Towson, Maryland Tina Saratsiotis / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Demetrio's Cem. 12/1/2007 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature Janeral 1050 York Road Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONGRITIUR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** HROW Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of) Examine The law requires that the death certificate be executed HEROSCIR and burial-trar Division or Vital Records, P.O. Box 68760 Be Completed by Physician/Medical as the attending properties as IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the a detached for ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de SYNDROME 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 🗌 Yes 2 2□No certificate 1∐ Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) director. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

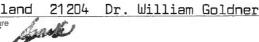
Registrar

7601 Osler Drive 31. Date filed (Month, Day, Year) State

NOV27

29b. Signature and title of cort

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Towson, Maryland 3 Registrar's Signature



D0018662

29d. Date signed (Month, Day, Year)

00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2007 1 - State Registrar 2 Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) November Day 22 2007 **Physician** Shoemaker 03:00 AM Elsie W. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Timonium 2313 Eastridge Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 16 1938 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F MD 69 220-36-8104 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Timonium Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 2313 Eastridge Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bottomley Williams Grace Unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2313 Eastridge Road, Tomonium, MD 21093 Robert E. Shoemaker (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date 27 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 2007 Baltimore, Maryland 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Function Service Li lense Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one complicates the complex of t Immediate Cause (Final disease or condition resulting in death) breast 22 month to metas Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe Completed by 2 →NO 3 □ Probably 4 □ Unknown 1 Tyes peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has certificate or Attending Physician: 26. Place of Death Check onl one funeral director, 25. Was case referred to medical Medical Certification: To Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 4 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 024732 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/wost rd, NO 72 32 istrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 29d, perMD, 6873, 11/27/07 TICertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 23 2007 С. Stallings 5 4 1 November Fern /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Severna Park Anne Arundel County Genesis Severna Park If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 ■ M 2 X F 87 214-14-0612 Maryland July 16, 1920 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hydene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 No N/A Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21230 1709 Belt Street Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. Specify: 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Housewife 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie C. Brady Irving M. Boswell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6204 Waterloo Road, Columbia, Maryland 21045 19a. Informant's Name/Relationship (Type. Print) Patricia Justice (Daughter) 20b. Place of Disposition (Name of cemetery) crematory or other place) Mays Chapel Cemetery 11-26-07 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home P.A. 21. Signature of Fun all Service Lice 130 East Fort Avenue, Baltimore, Maryland 21230 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Vasculer evela disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit that initiated event resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 21 No

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Be 2 Medical Certification:

ed by the a detached f certificate this After death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

10

State Registrar 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

NOV 2 7

5 ☐ Pending investigation 6 ☐ Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a Date of Injury (Month, Day Year)

and manner stated.

28c. Injury at Work?

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Other: 4 Hursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

10555

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number November 23,

dress of person who completed cause of death (Item 23a) (Type, Print)

200

501 enm 32/Registrar's Signature

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P.O. B	at the death
n or Vital Records, P.O. Box 68760,	The law requires the
or Vital	2
vision (	Attending Physicia

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ner	Baltinon 5. Social Security I	Number 8.	ive street and number)  The Medical  Sex  T. Ag  1 M 2 F	Centu je (In yrs. last b	birthday) Yrs.	4b. City, Town, of CLE If Under 1 Year Months Days		E B Date of Birth	A	9 Bi	ARUNDEL	
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Director	MD 10e. Street and Nu	Anne A	rundel —	Gle	n Bu	rnie			10~ Citi-	zen of What C	1 □ Yes 2 📉	
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Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of I	Hispanic Origin? (S ean, Mexican, Puer	Specify Yes or No-		14. Race - Am Black, Whi		
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du	Elementary/Sec		College (1-4or	5+)	_	OONOT use retire Veyor	during most of wo		Н	ousing		
	17. Father's Name	(First, Middle, Las	st)			,	18. Mother's Na	me (First, Middle,				
To Be	Arthur	E. Timme	ons				Sylv:	ia White				
		Name/Relationship		19		•	and Number or R					
	Mrs. Bre		ons / Wife	20h Place		7 Norfol	k Road (	Glen Bur		MD 2	1061	
	1 🗌 Burial 2	Cremation 3	Removal from State	ceme	etery, cren	natory or other pla	ce) tion 11-			•	lle, MD	
1		5 Other (Spec			-		;	- 1			Cremation	
	Su	Elone	M WILL	0147		1 2nd Av	e SW Gl	en Burni	e, M	D 2106		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. PULMONARY HYPERTENSION											
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•	Due to (or as	a consequenc	of):	<b>'</b>	W. State of the State of				1 year	
dical Examiner	Sequentially list c if any, leading to i cause. Enter Und Cause (Disease that initiated even resulting in death)	conditions, immediate lerlying or injury its	Due to (or as  Due to (or as	a consequence a consequence a consequence	of):  IV E  ce of):  Q1	Hyper Hear Jeny I	W. State of the State of	N LURE			1 year 2 year	
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 23 200 OVEMBER James Rutherford Thomas 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ARUNDEL ANNE EDIVAL GUEN ENTER 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number Year) Months Days Hours 1⊠M 2□ F 564-50-9175 1940 TX Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🔯 No Anne Arundel MD Glen Burnie 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 2 Birch Ave. 21061 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify. 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Rutherford James Talbot Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 114 Ferdinand Ave.; Glen Burnie, MD 21061 Mrs. Sheri Bachmann/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec. 17. 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 □ Donation 5 □ Other (Specify) Arlington Nat'l Cem. Arlington, VA 21. Signatury of Junyal Sarvice Licensee 22. Name and Address of Facility Singleton Funeral and Cremation M01411 1 2nd Ave. SW; Glen Burnie, MD 21061 23a. Pa/11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Paset and Death Immediate Cause (Final disease or condition resulting in death) a consequence of): Due to (or neumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. al 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner?

**Physician** /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

HOMAS, JAMES

the burial-transit attending physician this 4 hours after death. filled in by within 24 hours at To the Funeral C

Hospital or Attending Physician: The law requires that the death certificate be executed

the

Division or Vital Records, P.O. Box 68760,

Examiner ca Certificati

Medical

Med
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To Be C
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F FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 🗌 Unknown

1 ☐ Yes 2 📆 No

27. Manner of Death

1 Natural 2 ☐ Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

26 Place of Death (Ch

ner (Specify)

				20. 1 1006 01 Dec	an lo	icon only only	
Ho	ospital: 1 npatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursing H	lome	5 Residence	6 □Other
	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	28d.	Describe how inj	ury occurred

5 Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

and manner stated.

39. Name and address of person who completed cause of death (Item 23a) (Type, Print) GAVIRIA

31. Date filed (Month, Day, NOV 2 7 2007 32," Registrar's Signature

State

Registrar

				Please	Type or										_egit	ole.		
			For State Registrar		State	ot Ma	aryland	•	artment ( rtificate			na ivi	ental Hy	giene Bea No '	2.0	07	270	- 20
$g_{-\frac{d}{2}}$	Dhysisia		Decedent's Name (First, Middle, Last)										2. Date of Death Month November 25, 2007				3. Time of	Death 3
	Physicia /Medic	al	Margaret 1  4a. Facility Name (If not in			mbor)		1	4b. City, To	un or l	ocation of		Novembe			07 of Death	1:30	Ам
	Examin	er	Gilchrist			imber)			_	OWSC		Deam		40.	County		timore	
	Funeral		5. Social Security Number	r 6. S		7. Age	e (In yrs. Ia 79	st birthday) Yrs.	If Under 1		If Under 2 Hours	Min.	8. Date of Bir (Month, Da January	th y, Year)	220	9. Birthp	lace (State o	r Foreign
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and d be file	d othe	Be	17. Father's Name (First, David Was										(First, Middle Schmid		Surnam	e)		
should	nd Mer marke imatic	ဥ	19a. Informant's Name/F		Type. Print)			19b. Mailir	ng Address (S				al Route Numb		r Town,	State, Zip	Code)	
and 2 s	or Heams and Mental Hygener in the mass 23a or 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Albert Vo	gt-spo	use								kville					
more Pages 1	Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition  X□ Burial 2 □ Cre	emation 3		State	Sacre	ace of Dispo emetery, cre O Hear	sition (Name matory or oth Of Jes Ery	of er place <b>US</b>	)		Date	20c. Lo		-	own, State	
Saltimol	ortme ortant injury		4 □ Donation 5 □									10V 10	28, 2007	8800	0 Ha	rfor	d Road	
יַּבּ מַ	Impor any ir		Cordial	hy	no yao	6			Name and AVANS FUND CR				RVICE		rkvi.]	lle,Ma	iryland	
<b>D</b> 1	8		23a. Part1. Enter the dis shock, or heart failu Immediate Cause (Final	sease, or com ure. List only	plications that one cause on	caused each lin	the death.	. Do not ent	er the mode	of dying	, such as						Approximate Interval Bett Onset and I	ween
//\	ysician ⁄ledical		disease or condition resulting in death)	-	a. CONU	(or as	a consequ	ence of):	HEA	#KJ		PH	ILUR			+	year	フ
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o <b>U,</b> e executed	ian and urial-transit	_	resulting in death) Last		Due to	(or as	a consequ	ence of):										1
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cert ×	tending r use a	an/M	IF FEMALE: 23b. Was decedent preg		23c. If yes, or		pf pregnar 2 □ Fetal		∃Ectopic preg	nancy				2		e of delive		/oor
- e	the att	ysici	in the past 12 mont 1 ☐ Yes 25 No 9 ☐ Unknown	ins?		nant at	time of de		Other (spec						Moi	nun	Day \	/ear
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ecords,	een sig											—			es 2 No 3 Probably 4 Unknown			
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	certificate ector, pag	Be Cc	25. Was case referred to examiner?	medical							26. Place	of Death	1  Yes ∩ (Check only	2 No one)	1	I □ Yes	2 No	
VISION OF VITA Attending Physician:	this al dir	ို	1 ☐ Yes 2 ☐ No  27. Manner of Death		Hospital: 1 _	Inpatie		ER/Outpatier 28b. Time o	nt 3 DOA		4 🗆 Nul		me 5 Resi				m) HOSP	ICE
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Spital	within 24 hours after death. <b>To the Funeral Director:</b> After completely filled in by the funer	al Ce			nysician: To th													
the Ho	the Fu	ledical	one)		miner: On the and ma			ion and/or in				th occur	red at the time					5)
P.	₩ To	Σ	29b. Signature and title	Certifier	-01	16	)		290.1	License	number	88	66				Day, Year)	7
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J	Sta	to	31. Date filed (Month, Da	e Dall	OS M.	X Registra	150 ar's Signat	5 0 5/	er Dr	2.	Dt.5	01,	Towso	NM	100	2121	04	
	Registr		NON		£4	Modera	, B.	fre	de la									

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	,	1 - For State Registrar	State of Maryland / [	Department of Health and M Certificate of Death	lental Hygiene	007 37640
		1. Decedent's Name (First, Middle, Last	)		2. Date of Death Month Day	3. Time of Death
Physic /Medi		CHARLES	W:/Iipms		NOJENBER 6	25 2057 8:18 PM
Exami		4a. Fecility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	4c. Co	ounty of Death
			top god	(than) If Under 1 Year If Under 24 Hrs.	S Coata of Birth	O Bidhplace (State or Fareign
Funeral Director		5. Social Security Number  367-30-7737  Usual Residence of Decedent	XII act a	thday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country),
land ow		10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits
Mary -f sh	ţ	md. N/F	+	Baltimore		1 Nes 2 No
h the	irec	10e. Street and Number	CT	10f. Zip Code	10g. Citize	n of What Country?
th wit	a	1399 (21)	more ST	2121/		USA
ING 21213-UU36  be filed within 72 hours after death with the Maryland hat Hygiene. Indicate them "natural", or tlems 23a or 28a-f show avent, the Mexical Exerting the notified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto		. Race - American Indian, Black, White, etc. pecify: Black
tural tour	ed b	15. Decedent's Edu	Year or Dates:	Decedent's Usual Occupation	16b. Kind	of Business/Industry
21215-0036 od within 72 hours af gjene. ar than "natural; or the Medical Exert	piet	(Specify only highest grad		(Give kind of work done during most of work life. DO NOT use retired)	ing Dep	vartment of
nd 2121 e filed within al Hygiene. I other then vant, the Mu	Con	12th	4yrs.	public worke	~ Jul	ohe works
and be file trail Hy ad oth avani	Be	17. Father's Name (First, Middle, Last)	, 11	18. Mother's Name	e (First, Middle, Maiden St	Iname)
arylan should be nd Mental n markad o umafic ave	2	19a. Informant's Name/Relationship (T	11 11 WY	o. Mailing Address (Street and Number or Run	al Route Number City or 7	Town State Zin Code)
Iore, Maryland ges 1 and 2 should be file t of Health and Mental H; if item 27 is marked out or other traumatic avant		Donna Zone		1800 Parkside D	M. Balto	2, md, 2,206
		20a. Method of Disposition			7 55001	ation - City or Town, State
Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State		1-07 OWI	não MICLS, MD
<b>프</b> 고등원을 .		21. Signature of Funeral Service Licen		0307.		TILTON Pass
Depa Impo	1	16/11/	YLI	Gary P, march F	.H. Balt	D. md. 21229
### Step 1. The price of the pr	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence  b. Due to (or as a consequence  c. Due to (or as a consequence	of):		Onset and Death
BOX 6 death certific e attending p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)	23	id. Date of delivery Month Day Year
ecords, P.O. law requires that the d as been signed by the 2 should be detached	by Ph	Part II. Other significant conditions co	ontributing to death but not resulting i	in the underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
rds, quires an signe					1 ☐ Yes 2 ☐	No 3 Probably 4 ☐ Unknown
<b>~</b> • − 8	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
of Vital F Physician: Th this certificate ral director, pag	Be	25. Was case referred to me examiner?	11		h (Check only one)	
of V Physic this ca	2	1 ☐ Yes 2 ☐ 110	Hospital: 1 ☐ Inpatient 2 ☐ EP		ome 5 Residence 6	
On C ding P h. After t	on:	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	(Month, Day Year)	Time of lnjury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred
	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		28f. Location (Street and City or Town, State)	Number or Rural Route Number,	
Hospita 14 hours Funaral	edical Co	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my knowledg niner: On the basis of examination an and manner stated.	je, death occurred at the time, date and place, nd/or investigation, in my opinion, death occur	and due to the cause(s) a red at the time, date and p	nd manner as stated. place, and due to the cause(s)
To the within 2 To tha comple	Me	29b. Signature and title of certifier		29c. License number	29d. Date	signed (Month, Day, Year)
F 3 F 0		Doube Red	whoe mo	B27744832	NEVE	moin 25, our
11/1		30. Name and address of person who o	completed cause of death (Item 23a)	(Type, Print)		
4+1		DANLES REBIVE	my BONS	Eury Waspiel &	TOO WEST	By Ishune-Street
St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	(Type, Print)  Eury Muspitel 3		

Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Robert O. Wright November 7:57 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1808 Park Avenue Halethorpe Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1XM 2□ F 61 28. 1945 Jamaica 214-68-2666 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD 1 ☐ Yes 2 No Baltimore Halethorpe Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1808 Park Avenue 21227 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 X No Specify: Black Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Optician Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Timothy Wright Willhemina Grant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Wright/Wife 1808 Park Avenue Halethorpe Md 21227 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition West Arundel Crematory 12-3-2007 Odenton, Maryland 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal frem State 4 Donation 5 ☐ Other (Specify) Ambrose Funerally Home, Inc. 1328 Sulphur Spring Rd. Arbutus Md 21227 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) renal **Physician** clen co morth /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical as the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performe death? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 ER/Outpatient 3 DOA ٩ 5 Residence 6 □Other (Specify) funeral To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 ☐ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11-210-70 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 32. Rajistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ASBEM.



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1904 hms George Elmer Washington Nov. 19 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 5009 Pembridge Avenue Baltimore 8. Date of Birth (Month, Day, Year Aug. 19, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 6. Sex Days Year) 1□M 2□F Months Hours 238-46-2301 76 1931 N. Carolina Director Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d, Inside City Limits r 28a-f show notified at 1∏Yes 2∏No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 5009 Pembridge Avenue 21215 USA items 23a must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 152 Yes 2 □ No 1952 — If Yes, Give Year or Dates: 1954 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)

Public Transportation Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Checker Cab Co. 12th\_grade Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Haskell Washington Isabelle Law ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 Pembridge Avenue Baltimore, Md 21215 Maidie Washington/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11/27/07
Garrison Forest Vet. Cem. 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Mourial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills,Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Fareral Service License aris and Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart future. List only one cause on each line. Immediate Cause (Inal Physician Atheroscle notic Vascular 2003 resulting in death) /Medical Due to (or as a consequence of): Examiner 40 CUA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit REDAL Cell Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the all Id be detached fo P.O. I 1□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Disonder 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s performed? 1□ Yes 2 No 6560 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at 1 Natural
2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/09 D20807

State Registrar

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31. Date filed (Month, Day, Year)

BALT, more. \$2. Registrar's Signature

21201

4 OJKOFF S ORIGINAL

54.

30. Name and address of perso ho compiled cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	iryiand /		tment of H ificate of L	eaith and iv D <i>eath</i>		giene Reg. No.			
os.			Decedent's Name (First, Middle, Last		т	T-J o b l			2. Date of De. Month		3. Time of Deals 4		
l.	Physicia /Medic			Gary	L.	Webl				per 23,200	07 6:25 A M		
	Examin		4a. Facility Name (If not institution, give	e street and number)		4		Location of Death		4c. County of D			
			1010 Foxridge		/t	4 1-44-4	Essex If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		more Co.		
	Funeral Director		213-40-0107	XXM 2DF	(In yrs. last)		Months Days	Hours Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country) [aryland		
	and w	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loca	ition				10d. Inside City Limits		
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	r 28a	Director	10e. Street and Number		-		10f. Zip Code			10g. Citizen of Wha	t Country?		
	th wit 23a c 1st be	al D	1010 Foxridge	Lane			21221				States		
10	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show diaal Examiner must be notified at	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 □ Yes 2 □ ★				ispanic Origin? (Spi in, Mexican, Puerto	ecify Yes or No Rican, etc.)	Black, V	American Indian, Vhite, etc.		
036	rai", o Exan	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		111	∐Yes 24ŪXNo	Specify:		Specify:	White		
21215-0036	in 72 ho "natui ledical	Completed	15. Decedent's Ed (Specify only highest gra	ade completed)		6a. Decede (Give ki life. DC	nt's Usual Occupa nd of work done of NOT use retired	ation during most of work ()	ing	16b. Kind of Busine	ess/Industry		
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b	e filed al Hygi other vent, ti	Be C	17. Father's Name (First, Middle, Last	)						, Maiden Surname)			
/lar	2 should be and Mental is marked o	2	Clyde Webb					Grace Wa					
Maryland	d 2		19a. Informant's Name/Relationship ( Mrs. Lillian M. W		e)	1010	Foxridg	e Lane I	al Route Numb	er, City or Town, Sta Maryland	te, Zip Code) 21221		
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □				tion (Name of atory or other place em . Park	ce) 11/2	Date 27/2007	20c. Location - City Baltimon	y or Town, State re, Maryland		
altin	permit. Pa Departme Important any Injury		4 □ Donation 5 □ Other (Special 21. S) nature Funeral Friedline		11	22.	Name and Addres	ss of Facility		f Dundalk			
	20 E # 9		more"	- 1-20	4	7	922 Wise	Ave. D	undalk.	Maryland	21222 Approximate		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each iir	sclen	atic.		og, such as cardiac	1	irresi,	Interval Between Onset and Death		
	Examiner	<u>ا</u>	Sequentially list conditions,	b. Cue to (or as	a consequen	ne of):							
V	outed id ansit	Examine	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
68760,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequen	ce of):							
687	- D 6	edical											
.O. Box	The law requires that the death certifith has been signed by the attending tage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3⊟E	Ectopic pregnancy Other (specify)	/		23d. Date o Month			
<u>а</u>	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions	contributing to death b	ut not resultin	ig in the und	derlying cause giv	en in Part I.			ite to the cause of death?		
COL	w requisions should	lete							24a. Was	an 24b. We	re autopsy findings available		
or Vital Records,		Completed							auto perf 1∐ Yes	ormed? dea	r to completion of cause of th? Yes 2 <b>X</b> No		
/ita	Physiclan: Th r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	Hospital:			3□ DOA Oth	26. Place of Dear					
OL	ohys this al dir	၉	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER	Outpatient  Bb. Time of	- OLI DOX	4 Li Nulsing Fi		idence 6 □Other how injury occurred	(Specify)		
on (	ling After fune	tion:	1X Natural 5 ☐ Pending	(Month, Da	y Year)	Injury	28c. Injur Wor M 1 □	k? Yes 2∐No	200, 20001100	now injury coodings			
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	f examination	edge, death n and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occu	, and due to the rred at the time	e cause(s) and mann , date and place, and	er as stated. d due to the cause(s)		
	To the within To the Comp.	Me	29b. Signature and title of certifier	) Depu	+1		29c. Licens	se number		29d. Date signed (1)	22 0 -		
	3		30. Name and address of person who	completed cause of o	leath (Hem 23	Ba) (Type, P	Print) H:11 CT	r. Luth.	عالتمم	Md.	21093		
		ate	31. Date filed (Month, Day, Year)	32 Registr	ar's Signatur	La	1/2	,					
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			Decedent's Name (	(First, Middle, Las	t)							2. Date of D	eath	Day	Vass	3. Time of Death	
	Physicia /Medic		Teresa Ly	ynn Wil	coxon							Novem		-	Year 2007	10:30 A	Λ
•	Examin		4a. Facility Name (If n	not institution, give	street and nu	mber)		4	b. City, Town, o	r Location	of Death			4c. County	y of Death		
			5900 Serei			- //			Rockvil.		er 24 Hrs.	1000			Montgomery		
	Funeral		5. Social Security Num	1	ex □M 2 <b>X</b> F	7. Age (In yrs. 60			Months Days	Hours		8. Date of B	Day, Ye	ar)	Cou	place (State or Foreigntry)	
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130	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1		12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2⊠ No ive	1.5.		s Decedent of H es, specify Cuba Yes 2X No	an, Mexic Specif		ecity Yes or N Rican, etc.)	10-	Bla	14. Race - American Indian, Black, White, etc.  Specify: White		
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e e	1 and Health em 27 ther t		James W.  20a. Method of Dispos		n/Husba				Serenity			OCKVII. Date	_	Mary.		20855	_
pairimor	Pages treent of I tant: If ite		1 ☐ Burial 2 ☐ 4 ☐ Donation 5	Cremation 3 ☐ Mother (Specify	)Entombm	State	_	Heav	ion (Name of tory or other place en Cemete	ery	Nove	mber 2007	Sil	lver :	Sprin	g, Maryla	nċ
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			23a. Part1. Enter the shock, or heart	disease, or comp failure. List only	olications that one cause on	aused the dear each line.	th. Do no	ot enter t	the mode of dyir	ng, such a	as cardiac	or respiratory	arrest,			Approximate interval Between Onset and Death	
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0	certifica oding ph	Med	IF FEMALE:														
O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?	1 ☐ Live	itcome pf pregn birth 2 ☐ Feta nant at time of a nown	al death		ctopic pregnancy other (specify) _	у					ate of deliv onth	ery Day Year	
7	that ned by deta		Part II. Other signific	ant conditions	ontributing to d	leath but not res	sulting in	the unde	erlying cause giv	en in Par	t I.	23e. Did	I tobaco	co use con	tribute to t	he cause of death?	
2	quires n sign	d by										1 🗆	] Yes	2 <b>X</b> ) No	3□ Pro	babiy 4  □Unknow	'n
necoras,	s bee	Completed										24a. Wa		24b.	Were auto	opsy findings availabl	ie
	The I	mo										per 1⊟ Yes	opsy formed 2 <b>X</b>	I?	death?	mpletion of cause of 2 □ No	
VIII	stan: artifica	Be C	25. Was case referre	d to medical						26. Pla	ce of Deat	h (Check only					_
2	Physician: r this certific ral director,	To	1 ☐ Yes 2 📉 N	0	Hospital: 1	Inpatient 2	ER/Out	patient	3 DOA Oth	ier: 4□ ľ		ome 5 <b>K</b> Re				fy)	
	iding P. h. : After t	Certification:	27. Manner of Death 1 Natural 2 Accident	5 Pending investigation		of Injury oth, Day Year)	28b. T	ime of ijury	28c. Injui Wor M 1 🗆	ryat rk? Yes 2[		28d. Describe	e how i	njury occu	rred		
VISION	Attending or death. ector: After by the fune	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place	e of injury - At h ling, etc. (Speci	ome, far	m, street	t, factory, office			28f. Location City or T	(Stree	t and Numi	ber or Run	al Route Number,	
5	Ital or irs afte ral Dii led in	Cert															_
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as tated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)										to the cause(s)					
,	To t with To t	Σ	29b. Signature and til	sline of certifier	a s	Acher	8		29c. Licens BS75	5917				_		Day, Year) 6, 2007	
	20		30. Name and addres	ss of person who	completed cau	se of death (Ite			int) Center I	rive	#200	), Silv	rer	Sprin	ng. M	D 20902	_
	Sta	te	31. Date filed (Month)		32	Registrar's Sign	ature				= 0 (	- , <u></u>			0, 11		
	Registr	ar	N	OV 2 7 20	07	Eggs s	B.	Goal	المنا								
					v			TO THE REAL PROPERTY.									

Anne	Wendy	Whitridge	
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ille vveilay vvi		State of Maryland / Department of Health  1- For State  Certificate of Death  Registrar		Reg. I	No. 200	7 27(1.							
Physicia ledical Exami	an/	Decedent's Name (First, Middle,Last)     ANNE WINSLOW WHITRIDGE		2. Date of Death  Month  November 14	Year	3/ Time of Death O 4							
<b>V</b> .			own, or Location of Deatl ysville		4c. County of Death Baltimore Cou								
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 220-62-0224 1 Months			MM/DD/YYYY) 9. Bir Foreig Co								
Aaryland 28a-f show any 1 at once.	or	Usual Residence of Decedent  10a. State	LE			10d, Inside City Limits 1 Yes 2 No							
th the Maryland 23a or 28a-f sho	Director	10e. Street and Number 12251 ROUNDWOOD RD. 2	Code 1030	10g.	Citizen of What Cou	ntry?							
death with or items 23 must be no	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify	nt of Hispanic Origin? (S Cuban, Mexican, Puerto		White, etc.	ican Indian, Black,							
, MD 21215-0036 and 2 should be lifed within 72 hours after death with the Maryland teath and Manel Hygie within 72 hours after death and Manel Hygie within them 27 is marked other than "natural", or items 23a or 28a-f 5te traumatic event, the Medical Examiner must be notified at once	ā	3 Widowed 4 Divorced of Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)			Specify: WH  6b. Kind of Business/								
215-0036 be filed within 72 nual Hygiene. rked other than '	Completed	4YRS CONCIERG:		ne (First, Middle, Mai	CONCIER	GE							
21215 uld be file Mental Hy marked o	Be	FREDERICK W. WHITRIDGE		ALIAFFER									
b, MD 21 and 2 should I fealth and Mer tem 27 is mar traumatic eve	٦	FREDERICK WHITRIDGE (FATHER) 10613 C		RD. STE	EVENSON,	MD. 21153.							
More		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Nam crematory or other place)  ST • THOMAS			Oc. Location - City or OWINGS	MILLS, MD.							
		Will R. Jaure 16924	Address of Facility W. JENKI YORK RD	MONKTON.	MD. 211								
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Int Between Onset Death  Due to (or as a consequence of):											
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause											
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x 687 h certific ending p use as th	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1	3 Ectopic pregr	nancy	23d. Date of deliver Month	y Day Year							
, P.O. Boy ires that the death signed by the att	by Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		cco use contribute to	the cause of death?							
cords, law require, has been sig	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of							
tal Rec sian: The certificate ector, page			6.Place of Death (Check	1 ✓ Yes 2 k only one)	No 1 ✓ Y	es 2 No							
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Divis spital or A tours after neral Dire	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, (Specify) Multi Family Apt. House	office building, etc.	or Town, Stat		ural Route Number, City							
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	29a. Certifier (Check only one) 2  Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurred	at the time, date and	d place, and due to the	ne cause(s)							
	2	29b. Signature and title of certifier  29c.	O.C.M.E.		9d. Date signed <i>(Mo</i> November 15, 2	,							
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, B	altimore, MD 2120	01									
S Regis	tate trar	31. Date filed (Month, Day, Year)  NOV 2 7 2007  32. Registrar's Signature	-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/25/2007 **Physician** 7:15 George Daniel Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Health Center Timonium Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F North Carolina 84 7/12/1923 Director 243-24-445B Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified MD Baltimore Timonium 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a or Examiner must be r 215 Belmont Forest Court 21093 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after l ☐ Yes 2 ☑ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ould be filed within Mental Hygiene. Elementary/Secondary (0-12) other than College (1-4or 5+) Engineer Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Bettie Worley Oscar Henry Williams Health and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau Dorothy E. Williams/Wife 215 Belmont Forest Court Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 11/28/2007 |Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Signature of Euneral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York Road Approximate Interval Between Onset and Death Mouffus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Multiple Physician disease or condition resulting in death) /Medical rosderatic cardionas cular disease years Examiner Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) 68760 Physician/Medical attending p IF FEMALE: Box 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) faulkner MD/6865N. Charles Street 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 79:01 WILSON November 22 2007 abeth. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (# not institution, give street and number) Examiner Boltiwove If Under 1 Year If Under 24 Hrs. DECOUR Baltimore HOSD, tal Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Maryland. Months Days Hours Min 215162442 1 M 2 F Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medica Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Yes 2 □ No afternove WD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Z 17. Father's Name (First, Middle, Last) Be ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trauonce. 3a lto 2426 W. Lanvale 20b. Place of Disposition (Name of 20a, Method of Disposition Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part / Enterthe disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHEROSCIEROTIC CORONARY ARTERY Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as ed by the attending I detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 3 ☐ Probably 1 Yes 2 🗌 No director, page 2 should Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate 1∐ Yes Be ( 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3 DOA 2 2 ER/Outpatient After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Funeral Director: 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5000 EDWARD (TIAM 1501 31. Date filed (Month, Day, Year) State NOV 2 7

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOWINI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Y HIMOVE Malurau1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2□xF 79 215-28-0640 Director 13, 1928 Maryland Oct Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No N/A Baltimore Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 30th Street 1921 E. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City School 42 should be filed within h and Mental Hygiene.7 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Substitute Teacher \$ystem Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any injury or other trainment Etta Virginia Osborne Levering Williams ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type. Print) 1921 E. 30th Street Baltimore, Maryland Earl Young, Jr./ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 urial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/27/07 Cem. Owings Mills, Md Garrison Forest Vet. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home uller 4210 Belair Road Baltimore, Maryland 2120 Varros 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit certificate be execute Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery ed by the attent detached for u 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 3 1 No Division or Vital Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ဂ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3E DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Hospital or Attending Year) 1 Natural 5 ☐ Pending investigation Injury 2 🗌 No 1 Tes within 24 hours after death. To the Funeral Director: / 2 Accident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tyrone Anderson 07-08468

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IK UNK	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No. 2007 37											
	R	- For State legistrar 1. Decedent's Name (First, Middle,Last)	Sertificate of	Deam		Re 2. Date of Death	g. No	3. Time of Death				
Physicia edical Examir			erson			Month October 31	Day Year , 2007	1845 hrs				
Parisa Examin	_	4a. Facility Name (if not institution, give street and number)		4b. City, Town	, or Location of Dea		4c. County of Deat					
		Prince George's Hospital Center		Cheverly			Prince Georg					
Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1			h(MM/DD/YYYY) 9. Bi Forei	rthplace (State or gnWashington,				
Director		577-08-7637 1XM 2 F 24	Yrs		Days Hours M	July 2	5, 1983 C	D. C.				
		Usual Residence of Decedent						10d. Inside City Limits				
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land f sho	힐	Maryland Montgomery	Gaithers	10f. Zip Coo			og. Citizen of What Cou	untry?				
Mary r 28a-	Director	10e. Street and Number  158 Sharpstead Lane			878		United St	i				
th the 23a o notifi			in IIS 13 W	1	f Hispanic Origin? (	Specify Yes or No-		rican Indian, Black,				
ath wi tems	Funeral	1 X Never Married 2 Married Armed Forces?	If \	es, specify Cu	ıban, Mexican, Pue	rto Rican, etc.)	White, etc.					
her de		1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Year	No 1	Yes 2X	No specify:		Specify: B	lack				
hours af "natural"	황	15. Decedent's Education (Specify only highest grade complete	ed) 16a. Decede	nt's Usual Occ	upation (Give kind life, DO NOT use	of work done	16b. Kind of Business	/Industry				
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5-0036 led within 72 Hygiene. other than "	Completed by	9th grade	One	шьтоле		ıme (First, Middle, I						
5-00 iled wit Hygien d other		17. Father's Name (First, Middle, Last)				_						
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	0											
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "natural", or items 23a or 28a-f ahe injury or other traumatic event, the Medical Examiner must be notified at once	F	Donna Anderson (Mother)					sburg, Mar	vland 20878				
and 2 and 2 Fealth item 2 traur	ŀ	20a. Method of Disposition	20b. Place of Dispo	sition (Name o	of cemetery,	Date	20c. Location - City	or Town, State				
Baltimore, permit. Pages I an Department of Hea Important: If ite	- 1	1 Burial 2 X Cremation 3 Removal from State	crematory or of Chesapea			v.10,200 nc.	Beltsvil	le,Maryland				
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Box 6876C death certificate the attending physe	cian/Me	23b. Was decedent pregnant in the	2 F	etal death	3 Ectopic pre	egnancy	Month	Day Year				
ox 6 eath cer attendi	sicie	4 Pregnant at tim	e of death 5	Other (Specify	)		ľ					
be degraphed by the graphed for	Phy	Part II. Other significant conditions contributing to death but	ut not resulting in the	underlying ca	use given in Part I.	23e. Did	tobacco use contribute	to the cause of death?				
, P.O. B ires that the d signed by the	by	Tate in Other Significant Social Control of the Con		, ,		1Ye	es 2 🗸 No 3 📗 F	robably 4 Unknown				
ords, F w requires is been sign should be	Completed					24a. Was		autopsy findings available to completion of cause of				
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Division of Vital Records, P.O. Box 6876( Hospital or Attending Physician: The law requires that the death certificate 4 hours after death. Funeral Director: After this certificate has been signed by the attending phy- tely filled in by the funeral director, page 2 should be detached for use as the b	So	OF Management to medical		26	Place of Death (Ch		2 10	163 2 110				
ital sician: s certi	Be	25. Was case referred to medical examiner?	2 V ER/Outpatie		Other:	ursing Home 5	Residence 6 O	her:				
of Viting Physic After this funeral dir	. To	27. Manner of Death 28a. Date of Injury	28b. Time o		c. Injury at Work?		how injury occurred					
ion C tending eath. tor: Af	tion	1 Natural 5 Pending Oct 31, 2007	1758 hrs		1 Yes 2 V No	Subject sit	ot by police					
r Atte ter des irecto n by ti	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	y - At home, farm, st	reet, factory, o	ffice building, etc.	28f. Location	(Street and Number or State)	Rural Route Number, City				
Divisipital or At ours after dieral Direct filled in by	Certification:	4 Medicide determined (Specify) Local				- 1		enue, Riverdale Park, M				
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my k	nowledge, death occ	curred at the ti	me, date and place	, and due to the car	use(s) and manner as	stated.				
To the Hos within 24 h To the Fur	Medical	(Check only one) 2 Medical Examiner:On the basis of examinand manner stated.	ation and/or investig			red at the time, dat	29d. Date signed					
	ž	29b. Signature and title of certifier			License number  O.C.M.E.		November 1,					
		Muna Brasill, ME	<del>-</del>		U.U.IVI.L.		1,70,0,11,50,11,7					
		30. Name and address of person who completed cause of dea		Penn Stre	et, Baltimore,	MD 21201						
4 11/		Melissa Brassell, MD Assistant Medical E		, cill Ste	ot, Dalamore,							
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's	Old Ignit									

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 7 1 - For State Registrer Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** 10:29p. November 2007 Ruth Hughes Adkins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Dorchester 207 Dorchester Avenue Cambridge Birthplace (State or Foreign Country) If Under 1 Year | ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

April 15, 1916 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🛛 F Yrs Director 214-07-7475 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location other treumatic event, the Medical Evantuar must be notified at 1 ☑ Yes 2 ☐ No Completed by Funeral Director Dorchester Cambridge 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 207 Dorchester Avenue 21613 Baltimore, Maryland 21215-0036  $igcup \mathbb{N}$ items 23s 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 5 1 ☐ Yes 🍇 No Specify: Specify: white 3 Nidowed 4 Divorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4or 5+) retail shipping clerk 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I ant: if item 27 is marked of Howard Hughes Flossie Estella Meredith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Dorchester Avenue, Cambridge, MD 21613
a of Disposition (Name of Date 20c. Location - City or Town, State Anna Ruth Pope daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) = 5 permit. Page Department of Important: if any injury or once. Greenlawn Cemetery 11/11/07 Cambridge, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final Metastatio Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2/100
9 Unknown 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by Breast Cancer, Pulmonary Embolism, Congestive heart 1 Yes 2 No 3 Probably 4 Unknown failure, osteoarthritis, Atrial Fibrillation, Frequent 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No urinary Tract infections, Macular Degeneration Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 \( \sum \) Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 5 X esidence 6 Other (Specify) 0 this 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After t Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 4 hours after death. 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) certifier 29b. Signature and title d OUS a 9 07 cause of death (Item 23a) (Type, Print) 30. Name and address Cambridge MD 21613 100 bramble AVNarr DO 31. Date filed (Month, Day, Year) 2007 NOV 0 9 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			1 - For State Registrar	State of Maryland / D	Department of He Certificate of D			eneZ U U /		
	Dhysisi		1. Decedent's Name (First, Middle, Las	1)	-		<ol><li>Date of Death Month</li></ol>	Day Year	3. Time of Death	
7	Physici /Medio		ALLEN R. BYRD				NOVEMBER		2336 <sup>M</sup>	
	Examir		4a. Facility Name (If not institution, give		4b. City, Town, or I	Location of Death		4c. County of Death		
			PRINCE GEORGE'S HO  5. Social Security Number 6. Se		CHEVER	If Under 24 Hrs.	8. Date of Birth	PRINCE GE		
	Funeral Director		n	714 00 5	rrs. Months Days	Hours Min.	(Month, Day,	Year) S. Billing	place (State or Foreign ntry)	
			579-54-9287 Usual Residence of Decedent	0./			ADF. 22,	1940 WASH	a g . Lalia	
	yland		10a. State 10b. County	10c. City, Town					10d. Inside City Limits	
	e Ma	cto	D.C.	WASHING	5TON				1 XYes 2 No	
	h with th	ai Dire	10e. Street and Number 5315 E ST., S.E.	<sup>‡</sup> 524	10f. Zip Code 20019			g. Citizen of What Cou NTED STATE		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Department of Heatin and Mental Hygiene. Department of Heating and Mental Hygiene. Department of the traumatic event, Ire Medical Exacting must be redified at Once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates:	13. Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	or No- 14. Race - American Indian, Black, White, etc.  Specify: BLACK		
21215-0036	2 hou	ted	15. Decedent's Ed	ucation 16a.	Decedent's Usual Occupat	tion	10	6b. Kind of Business/In	dustry	
215	Fin 7	ple	(Specify only highest gra-	College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)		ng	ROOFING		
2	giene giene er th	Completed	9th			ROOFER				
Maryland	be file	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Sumame)		
<u>X</u>	Men	ပ	JAMES BYRD			DEALIA		0) T 0) 17	. 0. 7.1	
<u>a</u>	12 sh h and 7 Is m Iraum		19a. Informant's Name/Relationship (7 DELORES BYRD/WIF)	,, ,	Mailing Address (Street at 15 E ST., S.)				Code)	
a)	1 and Healt em 2		20a. Method of Disposition	20b. Place of	Disposition (Name of	! .		Oc. Location - City or To	own, State	
Baltimore,	nt of nt of the History		1 Burial 2 Cremation 3	Removal from State cemeters	y, crematory or other place Y MEM PARK (					
	artme ortani injury	- 3	* 4 ☐ Dogation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	A	22. Name and Address	a p i l'acceptant de la company de la compan	1/0/ 1	ANDOVER, M	D.C.2000	
ñ	Departing Department of the poores.	ii li	23a. Part1. Enter the diseal e, yr comp	him-falley	CAPITOL MO					
,8760,	Cate be executed which is the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last	a. Due to (or as a consequence of the to (or as a consequence	λÎ).	ony m	red			
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7	juires that the signed by ald be detacted	b	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause give	n in Part I.		acco use contribute to t		
Vital Records,	The law require rate has been si page 2 should I	Completed					24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of	
II a		Be C	25. Was case referred to medical examiner?			26. Place of Death				
0	Physician: rthis certific ral director,	인	1 ☐ Yes 2√ No	Hospital: 1 ☐ Inpatient 2 X ER/Out		4   Nuising Ho		nce 6 Other (Speci	fy)	
0	fler t		27. Manner of Death 1- Natural 5 □ Pending	28a. Date of Injury 28b. T	njury Work'		28d. Describe hov	v injury occurred		
<u> </u>	Attending r death. ector: Afte by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be			es 2 No	006	and and Number on Pur	al Cauda Mumba	
Division	lor At after d Direct	Certification:	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office		City or Town,	eet and Number or Run State)	ai Houte Number,	
_	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edicai C		ysician: To the best of my knowledge inner: On the basis of examination and and manner stated						
	To the To the	Me	29b. Signature and title of certifier		29c. License			d. Date signed (Month.		
•	6		1	Lindel	75	8957		11-5-07	-	
	BY		30. Name and address of person who	completed cause of death (kem 23a) (	Type. Print)	Chever	les Da	11-5-07 D 2078	5~	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature			0			
	Regist		NOV 0 9 2007	March - H. Break	· /					

	/Med Exami Funeral Director	P
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at angle.	To Be Completed by Funeral Director

Physic /Medi Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director and 3 changed the Attendance of the buries and the buries are the buries of the buries and the control of the transfer of the buries are the buries and the buries are the buri

Division or Vital Records, P.O. Box 68760,

		1- State Registrar Certificate of Death	Rea	.No.2007	37654								
		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death								
sicia ledic		ATTAIL SAMEET DIMPORT	November	-	5:35 P M								
ımin	er	er 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath	4c. County of Dea	ath								
		5225 Pooks Hill Road #A22S Bethesda  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	Hrs. 8. Date of Birth	Montgom	thplace (State or Foreign								
ral tor			lin. (Month, Day, Y	ear) C	ountry)								
<u> </u>		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits								
most be notified at	tor	Maryland Montgomery Bethesda			1 ☐ Yes 2 ☐ No								
	Sire.	10e. Street and Number	10g	. Citizen of What C	ountry?								
a len	ral	5225 Pooks Hill Road #A22S 20814		United St									
D D	nne	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  11. Never Married 2 Married  12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Pull Yes, Specify Cu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, Whi									
EYall	ρ	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates:   1 ☐ Yes 2 ☐ No Specify:	Specify: wh										
בחופ	lete	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  4  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  Multi-family finance	working 16	b. Kind of Business	•								
	E O	Elementary/Secondary (0-12) College (1-4or 5+)  4 Multi-family finance		Housi	0								
1	Ö	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	Name (First, Middle, Ma		оршенс								
	<u> </u>	Sidney Birndorf Ac	dele Markin										
		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or											
5		Jesse M. Birndorf, Son 2906 Aquarius Avenue											
2		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Shalom Memorial Park 11,		c. Location - City or lington H	eights, IL								
once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Torchinsky Hebrey	w Funeral Ho	ome	20010								
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	NW, Washing diac or respiratory arrest	<del>gton, DC</del>	20012 Approximate Interval Between								
an		Immediate Cause (Final disease or condition Congestive Heart Failure			2 weeks								
cal		resulting in death)  Due to (or as a consequence of):											
ner		Sequentially list conditions.  Possible Myocardial Infarction											
i i	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Coronary Heart Disease  1 year											
	хаш	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Coronary Heart Disease  Due to (or as a consequence of):			1 year								
	ia E	H H											
22	edic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   1   Unknown   2   State   1   Other significant conditions contributing to death but not resulting in the underlying cause gives in Part I.											
Den l	M/	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de	elivery								
	sicia	in the past 12 months?  1   Yes   2   No   9   Unknown		Month	Day Year								
la la	Phy	9 □ Unknown	00 - Dilli										
	þ	A coming of dealing to dealing the dealing of the distributions continuous co		co use contribute t 2 ☐ No 3 ☐ P	o the cause of death?								
	eted	TI Dishata											
, d	ld m	Borderline Type II Diabetes	— 24a. Was an autopsy performe	d? 24b. Were a prior to death?	utopsy findings available completion of cause of								
, n			1  Yes 21	]No 1 ☐Yes	s 2□No								
	o Be	examiner?	Death (Check only one)  Ig Home	o e DOther (Cn.	noife)								
	<b>-</b> }		28d. Describe how		acity)								
2	atio	1X   Natural   5   Pending   (Month, Day Year)   Injury   Work?   2   Accident   investigation   M   1   Yes 2   No											
n 60 III 0	ertific	27. Manner of Death  1\( \) Natural 2 \  Accident 3 \  Suicide 4 \  Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M 28c. Injury at Work? 1 \  Yes 2 \  No  28e. Place of injury - At home, farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Fi State)	lural Route Number,								
aller aller		29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number	lace, and due to the caus occurred at the time, date	se(s) and manner as and place, and du	is stated. le to the cause(s)								
	29b. Signature and title of certifier  29c. License number  D 11921  29d. Date signed (Month, Day, November 8, 20												
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  John A. Gallotto, M.D., 5225 Pooks Hill Road, Suite 1	-A. Rethesd	A. Bethesda, MD 20814									
Sta	· 6	31. Date filed (Month, Day, Year) 32 Registrar's Signature	, Deanesa										
Sta gistr		NOV 0 0 2007											

Registrar

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			1 - For State Registrar	State of Mary				lealth a Death	nd Me	_	gier Reg. N	$2  \mathrm{n}$	07	3763	55
	Physic		1. Decedent's Name (First, Middle, La.  Rebecca Brambl	•					1	2. Date of De Month	ath	ay	Year 0 0 7	3. Time of Dea	
)	/Medi Examir		4a. Facility Name (If not institution, give			4b. City	, Town, or	Location of	f Death	!		c. County	of Death		
	Funeral Director		221-10-0002		yrs. last birthday,	) If Und	esto: er 1 Year Days	If Under 2 Hours	Min.	3. Date of Bir (Month, Da July 4	rth ay, Yea , 1	<b>Tal</b> l 916	9. Birth	place (State or Fo ntry) Land	reign
	fanyland ahow	٥٠	Usual Residence of Decedent  10a. State 10b. County  MD Talbot		c. City, Town or L East			-						10d. Inside City Li	
	with the A 3a or 28a-1	I Direct	10e. Street and Number 610 Dutchman'		Last		ip Code	1601			_	itizen of V		ntry?	
980	ilied within 72 hours after death with the Maryland Hygiene. uther than "naturel", or items 23a or 28a-f ahow ont, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  1∑ Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:	r in U.S. 13.	Was Decilif Yes, sp		ispanic Orig in, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No can, etc.)		14. Rac Blac		can Indian, etc.	
21215-0036	ed within 72 ho giene. er then "natur , the Medical.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)			edent's Us e kind of w DO NOT sthe	rork done d use retired	during most ()	of working	7		Kind of Bu		dustry	
	d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "renmatic event, the Med	To Be (	17. Father's Name (First, Middle, Last) William Claren	2015 0-04	9			18. Mother Audr	's Name ( ey W	First, Middle ilson	Maide 1 B	n Suman ramb	1e 1	ruitt	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23s or 28s-f ahow any njury or other traumatic event, the Madical Examinat must be notified at ance.		Peggy Williamson/  20a. Method of Disposition  1 Surial 2 Cremation 3	Sister Removal from State		lylon osition (Na matory or	Blvd ame of other plac	l., Se	aforo Da		199 20c.	73 Location -	City or To	o Code) own, State Maryla	n d
Baltin	permit. P. Departme timportant any njury once		4 Donation 5 Other (Specification 21. Signature of Funeral Service Licen							otom F <sup>.</sup> eralsb					
1	Cate be executed which is care be executed whysicien and purial-transit the burial-transit	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	liomyop Insequence of): Wasion Insequence of): Insequence of):	rethy	de of dyin	g, such as c	ardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death Upans  Jeans  Jeans  Jeans	0
O. Box 68760,	ne death certifi the attending I thed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d. 23c. If yes, outcome of p 1 Live birth 2 4 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic ( ⊒ Other (s						23d. Dat Mo	te of deliventh	ery Day Year	
rds, P.O	quires that ti n signed by uld be detac	þ	Part II. Other significant conditions of OSfeopore	ontributing to death but no	ot resulting in the u	inderlying	cause give	en in Part I.					ribute to ti	ne cause of death	
of Vital Records,		Completed								24a. Was autor perfo			Were auto prior to co death?	psy findings avail mpletion of cause 2 No	able of
Zi.	ysician: 1 is certificel director, p	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	nt 3□ D	OA Othe			Check only o		€ □Oth	or /Socoil	i.)	
Division of	anding Ph ath. ar: After th	Certification: T	27 Manner of Death PSNatural 2	28a. Date of Injury (Month, Day Ye	ar) 28b. Time of Injury	f M	28c. Injury Work		28 o	d. Describe	how inj	ury occurr	red	il Route Number,	
Ö	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	edical Cert	29a. Certifying Ph	building, etc. (S ysician: To the best of mainer: On the basis of exa	v knowledge, deat	h occurred	at the tim	e, date and	place, an	City or To	Called/	e) and ma	inner as s	tated.	
)	To the by within 24 To the Complete	Med	29b. Signature and title of certifier	Allowley,	Net		c. License		93			ate signed		Day, Year)	
	Sta Registr		30. Name and address of person who do not be a michael Crow 31. Date filed (Month, Day, OV 1	completed cause of death  11 e.y			ane	East	on,	MD 21	60	1			

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State	riease i	State of Ma		d / Depa	artment of H	lealth and N	-	_	Die.			
		Registrar				Cei	rtificate of	Deam		g. No. 2	107	27656		
Physicia /Medic		1. Decedent's Name (First Walter	t, Middle, Last) Bli	ff	Bowma	an			2. Date of Death Month November	Day	Year 007	3. Timelof Death U		
Examin		4a. Facility Name (If not in	stitution, give s	treet and number)			4b. City, Town, o	r Location of Death		4c. County of Death				
		2215 Cape 1	Leonard	Drive				eonard		Ca	lvert	<u> </u>		
Funeral Director		5. Social Security Number 243–01–055	1 1 X	7. Ag	e (In yrs. Ia 91	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 15	<sup>Yea</sup> r) 1916	Cour	place (State or Foreign htry) Ch Carolina		
pu ,		Usual Residence of Deceded 10a. State 10b.	County		10c City	, Town or Lo	ocation				1	0d. Inside City Limits		
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er de	Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?		5.   13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)		ce - Americ ck, White,			
s aft	γF	1 □ Never Married 2 3 □ Widowed 4 □ D		1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:	NO		1 ☐ Yes 2 ☑ No	Specify:		Specif	<sup>iy:</sup> Whi	+0		
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shoul od M mari	Ĕ	19a. Informant's Name/R	<del></del>			19b. Mailir	ng Address (Street	and Number or Rui				Code)		
ulth al 27 is r trau		Estelle C.	Bowman	, spouse		221	5 Cape L	eonard Dr	ive, St.	Leona	rd. M	1D 20685		
Hea Hea tem		20a. Method of Disposition		,	20b. PI	ace of Dispo	sition (Name of	1		Oc. Location				
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at once.		21 Signature of Funeral		×e	Auta			ss of Facility Ra		Hanove eral H	,			
permi Depa Impo any i	,		<u> </u>	1				Mt. Harmo						
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Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	T a	Due to (or as	10C	ardio	d I	nfarch	D'A			Interval Between Onset and Death		
uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
sate be executed hysician and the burial-transit	cal	<u>8</u>												
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregrin the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	iaiii	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	⊒Ectopic pregnanc ⊒ Other <i>(sp</i> ec <i>ify)</i>	y			ate of delive	ery Day Year		
that the		Part II. Other significant	conditions con	tributing to death b	ut not resu	Iting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use con	tribute to t	he cause of death?		
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teath tor: , the f	cati	2 Accident 3 Suicide 6 □	investigation Could not be	00 - Di(i-i				Yes 2 □ No	001 1			1.5		
or Al	Certification:	4 ☐ Homicide	determined	building, et			reet, factory, office		28f. Location (Str City or Town		ber or Hura	M Houte Number,		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director after this certificate has completely filled in by the funeral director, page 2.		(Check only 2 1		ner: On the basis of	of examinat			me, date and place						
the the The	Medical	one)	conific	and manner st	ated.		29c. Licens	e number	00	d. Date sign	ad (Manek	Day Voorl		
5 W I		29b. Signature and title or		As \			250. LICETIS	C. C. ( [ C.	,	u. Date sign	a (Worth,	Day, Ieal)		
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		30. Name and address of	person who co	mpleted cause of o	leath (Item	23a) (Type,	Print)	5. 7/.	Prince	C	0 . 1	- 00 7N-0		
W   Sta	to	31. Date filed (Month, Da	Year)	32. Registr	s Signat	ture K	1 / 741	He )(8	rince	Tred	er:ch	C MU CUK		

Registrar DHMH 17 Rev 1/2001

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Charles J. Breen, Sr. 11/5/2007 0014 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Hospital Elkton ( If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/10/1938 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Hours Days 69 211-30-7711 Director PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at show 1 ☐ Yes 🏖 No Director MD Cecil Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 16 Beechwood Rd. 21919 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: an "natural", or items Medical Examiner me Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene is marked other than "natural", or ite 1 ☐ Never Married 2 Married 1 ☐ Yes 2 💢 No White Specify. δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Roofer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Breen Mary Lawler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 i Anne Breen/wife 16 Beechwood Rd. Earleville, MD 21919 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h
Important: If ite
any Injury or of tX Burial 2 ☐ Cremation 3 ☐ Removal from State SS Peter & Paul 11/10/07 Springfield, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fellows, Helfenbein& Newnam 21. Signature of Funeral Service Licensee 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Seps.s Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Spontaneous Bacterial Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Cirrhosis with end stage liver disease The law requires that the death certificate be executed g physician and as the burial-tran Due to (or as a consequence of) Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) been signed by the a should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

altimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29c. License number 29d. Date signed (Month, Day, Year) 11/5/07 D0053675

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Montelcone, me)

and manner stated.

W. High St. Suite 214, Elkton MD 21921 111

State Registrar

Medical

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 NOV. 5, 03:15 P M Herman Allan Blizzard 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **KENT** CHESTER RIVER MANOR CHESTERTOWN 8. Date of Birth (Month, Day, Year) JAN. 26, 1926 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 1 X M 2 ☐ F Days Hours Months MD 214-20-9344 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No KENT WORTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26880 BIG WOODS RD. 21678 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SHERRIFF LAW ENFORCEMENT 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HATTIE E. COLLIER CHARLES T. BLIZZARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26870 BIG WOODS RD. WORTON, MD 21678 19a. Informant's Name/Relationship (Type. Print) JOSEPH BLIZZARD/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATION 11/9/2007 STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM 21. Signature of Funeral Service Licenses Kick of 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROSTATE CANCER WITH METASTASES months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to Conse a consonuanta offi Due to (or as a consequence of): If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

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Box 68760.

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Division or Vital Records,

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

filed withir Hygiene.

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permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If Item 27 is marken any injury or control.

3altimore, Maryland 21215-0036

Examiner Physician/Medical

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Certification:

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 ☐ Inpatient

DIABETES

24a. Was an

autopsy performed 26. Place of Death (Check only one

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only

1 Natural

2 Accident

3∏ Suicide

4 Homicide

📂 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Speer Rd., Chestertown, MD 21620 Helen Noble, MD, 122 31. Date filed (Month, Day, Year)

State Registrar

NOV 0 9 2007



DHMH 17 Rev 1/2001

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		For State Registrar			ıvıaryıar		Certifica			ırıa N	Mental Hy	Reg. No	- 211	07		659
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/Medio				n, give street and num	ber)		4b. City	, Town, o	r Location of	f Death			c. County of	Death	1.50	
Function	o A	HERON P  5. Social Security N		6. Sex 7	. Age (In yrs.	last birth		CHEST or 1 Year	ERTOWN		8. Date of B	irth	KEN		lace (State o	r Foreian
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leath certific attending p	n/Me	IF FEMALE: 23b. Was deceden		23c. If yes, outc	ome pf pregn		3 □Ectopic į	Yognana					23d. Date	of delive	ry	
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical	(Check only one)	2 ☐ Medical	Examiner: On the bas	is of examina	ation and/	or investigation	n, in my c	opinion, deat	th occur	rred at the time	, date ar	nd place, ar	nd due to	the cause(s	)
_	Σ	29b. Signature and	title of certife							30			ate signed			
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			For State Registrar	Ctate of Int	Ce.	rtificate of	Death	iornai rij	Reg. No.	UI	37650
	3 1	8	Decedent's Name (First, Middle, Last)	1				2. Date of De	eath Day	Year	3. Time of Death
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			THE JOHNS HOPKI				, -	-174		T	·····
	Funeral		5. Social Security Number 6. Sex	( 7. Ag ]M 2⊠F	e (In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ay, Yea <i>r</i> )	Coun	lace (State or Foreign try) ylvania
	Director		577-24-6616 Usual Residence of Decedent		85 115.			March 2	1922	reillis	yivania
	yland low at		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Man a-f sh ified	tor	Maryland Montgome	ry		Chevy (	Chase				1 ☐ Yes 2 ⊠ No
	th the or 28 e not	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	23a ust b	ral	4701 Willard Avenue	-		_1	0815			U.S.A	
	er dez	Funeral	TTT Marital Olding	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	D- 14. Ra	ce - Americ ack, White,	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No			Speci	WI	nite
5	72 h "natu dical	ete	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i>	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ring	16b. Kind of B	Business/Ind	lustry
21215-0036	d within giene. er than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+) <i>IIIe.</i>	Co-Owner	<i>a)</i>		Retail	Record	s & Books
nd	al Hy d other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	e, Maiden Surna	me)	
ya	ould by Ment arked arked artic e	2	Nathan Bick					Kutcher			
Maryland	2 sh and is m		19a. Informant's Name/Relationship (Ty			,	and Number or Rui				Code)
e)	1 and Health		Debra Bialek Klein - 20a. Method of Disposition	Daughter	20b. Place of Dispo		Street, Ken	sington, Date	Maryland 20c. Location		iwn State
آو	nt of h		1 ☑ Purial 2 ☐ Cremation 3 ☐ F		cemetery, cre	matory or other pla	ce)				
Baltimore,	iit. Partme		4 Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Lice is	-		on Cemetery  2. Name and Addre		/2007	Ade1phi	, Maryı	.and
Ba	permii Depar Impor any Ir once.		1 June	n. Th	H:	ines-Rinald L800 New Ha	i Funeral H mpshire Ave	nue, Silv	er Spring	g, Mary	1and 20904
Г			23a. Part 1. Enter the disease or compleshock, or heart failure. List only of	ications that caused ne cause on each li	I the death. Do not en ne.	ter the mode of dyi	ng, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
7	Physician		Immediate Cause (Final disease or condition resulting in death)	a. EN	CEPHAL	OPATH	1			5	1x WEEKS
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
	. **	Je Je	Sequentially list conditions,	bb.	a consequence of):						
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	_ == (	,						
Ć,	te be executed ysician and ne burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):						
760,	te be ysicia e bur	cal		d							
68	rtifica ng ph as th	ledi	IS SERVALE.			* .					
D. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death 3	□Ectopic pregnand □ Other <i>(specify)</i> _	y .			ate of delive	ery Day Year
P.0	that the ed by detac	Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did	tobacco use co	ntribute to ti	ne cause of death?
or Vital Records,	quires n sign lid be	d by						1 🗆	Yes 2 DNo	3∏ Prot	pably 4 □Unknown
00	w red s beer shou	Completed						24a. Wa:		. Were auto	psy findings available
Re	The la te has age 2	dmo			-				opsy formed? 2 \Begin{array}{c} No	death?	mpletion of cause of
ta	an: rtifica tor, p	Be C	25. Was case referred to medical				26. Place of Dea			10100	282110
<b>r</b> <	Physician: this certificated director, is	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpati	ent 2 ER/Outpatie	nt 3□ DOA Oti	her: 4 🗆 Nursing H	ome 5□Res	sidence 6 🗆 O	ther (Specia	(y)
o uo	Attending PI r death. ector: After the funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ury 28b. Time ( Injury	Wo	ryat rk? ]Yes 2∐No	28d. Describe	how injury occi	urred	
Division	l or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of in building, e	ury - At home, farm, st c. (Specify)	reet, factory, office	-		(Street and Nun own, State)	nber or Rura	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Co			of my knowledge, dea of examination and/or i						
	o the	Med	29b. Signature and title of certifier	and manner st	uicu.	29c. Licens	se number		29d. Date sigr	ned (Month,	Day, Year)
	⊢ s ⊢ ŏ		1	5 MET	ILAL DOLT	RRE	5-000		NOVEMBE	50 5	2007
	20		30. Name and address of person who co				, , , , ,	l	VU VE/MISE		712.87

State

Registrar

MAULIK MASMUSAR, THE JOHNS HOCKINS HUSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MALYLAND

31. Date filed (Month, Day, Year)

NOV 0 8 2007

ACCOUNTS HOCKINS HUSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MALYLAND

ACCOUNTS HOCKINS HUSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MALYLAND

ACCOUNTS HOCKINS HUSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MALYLAND

21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Nevember 2007 Jilliam /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Harford avre De Grace Mursing Home tizens 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Security Number **Funeral** Min Months Days Hours 1 X M 2 ☐ F Yrs. 215-32-5490 70 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location sa or 28a-f show t be notified at 1 XYes 2 No Funeral Director Havre de Grace MD Harkord 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must he resonce. 100 Revolution Street, Apt. 408

1. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 21078 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. I RYes 2 No
If Yes, Give
Year or Dates: 1956-62 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pipefitter Civil Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Bruon Boud Anne Veronica Abbott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Darlene Gray (Daughter) 264 Porcher Street, Dover, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/17/2007 Havre de Grace, MD Mt. Erin Cemetery 4 ☐ Donation 5 ☐ Other (Specify) natural Service Licensee 22 Name and Address of Facility Smith Funeral Home 123 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) of the Esophague 2007 Physician /Medical Due to (or as a consequence of): "Ca to Choroid Left eye 10 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 TUnknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

LETICIA

S. GALVEZ, 32. Registrar's Signature

M.D. 625

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. UNION AVE. HAURE DEGRAGE

State Registrar D-15994

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 37662 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5, 2007 Physician November 2153 Gilbert Fern Brisson, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital of Cecil County Elkton Cecil If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In vrs. last birthday 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1X M 2 □ F Director 529-50-7202 67 Oct. 17, 1940 Virginia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Elkton Director Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Montrose Lane U.S.A. 21921 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify. 2 White 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Air Force Staff Sergeant one vear 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gilbert Fern Brisson, Sr. Gladys Alderton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10023 Collins Hole Road, Tallahassee, Florida 32312 (Daughter) Beth Maykut 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/09/07 Garrison Forest Cemetery Owings Mills, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Us pulled ales aluse /Medical Due to (or as a consequence of): **Examiner** Abronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner OHUG. been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2√ No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2**½** No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury 28d. Describe how injury occurred 27 Manner of Death 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day,

()BRMA

29b. Signature and title of certifier

106 STREET 32. Registrar's Signature

Bow

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DU066327

29d. Date signed (Month, Day, Year)

10.301

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			4 101	partment of Health and Meartificate of Death	ental Hygier	21111 / 3 /663				
	Physici		1. Decedent's Name (First, Middle, Last)  Jesse Thomas Bennington			Day Year 08:08 A M				
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death							
	4	¥	100 Lapidum Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Havre de Grace  If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Harford  9 Birthplace (State or Foreign				
¥	Funeral Director		219-22-5969 18€ M 2□F 79 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 03/10/192					
	ryland		10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits				
	he Ma 28e-f	Funeral Director	0	de Grace		1 ☐ Yes 2XNo				
	With t	I DI	100. Street and Number	10f. Zip Code 21078	10g. (	Citizen of What Country?				
	death	nera	100 Lapidum Road  11. Marital Status	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - American Indian,				
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other then "naturel", or Items 23a or 28e-f show or other traumatic event, the Medical Examinat must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1950-51	1 ☐ Yes 2 X No Specify:	ncan, etc.)	Black, White, etc.  Specify: White				
2-0	72 hounature		15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of workin	16b.	Kind of Business/Industry				
21215-0036	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)						
	e filed within Hygiene. other ther	Be Co	17. Father's Name (First, Middle, Last)	pat Captain 18. Mother's Name		ivil Service en Sumame)				
/lan	Mental Mental arked c	To B	Paul DeWitt Bennington	Anna Pri	ce					
Maryland	12 shou h and M 7 Is mar raumati			ling Address (Street and Number or Rural						
	Health tem 27 other tr			Lapidum Road, Havre position (Name of paratory or other place)		Location - City or Town, State				
OE.	Pages nent of int: If I		A Burial 2   Cremation 3   Hemoval from State	Mem. Gardens 11/19	/2007 Ab	erdeen. Maruland				
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny injury or ot		21 About to of Euporal Society Licenses	20 Name and Address of Escility						
	40 = 0 d	- (	23a. Part1. Enter the disease, or complications that caused the death. Do not e.	Zellman Mitchell S 123 S. Washington S. There the mode of dying, such as cardiac or	t., Havne	de Grace, MD Approximate				
H	Physician		shock, or heart failure. List only one cause on each line.	· -	-	Interval Between Onset and Death				
100	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0 - 0 -	. 0 -	-2				
	* 3 · 80	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	your ace	^ele	1 .				
1	scuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of)	! Colan						
8760,	icate be executed physicien and s the burial-transit		Due to (or as a consequence of)							
9	tificate ng phytas the	ledic	<u> </u>							
Вох	death certific e attending p od for use as	lan/N		□Ectopic pregnancy		23d. Date of delivery  Month Day Year				
P.O.	the de y the a	Physician/Medical	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5	Other (specify)						
s, P	es thet the death certifica igned by the attending ph be detached for use as t	by Pł	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?				
ord	w requir been si should	eted			1 🗆 Yes					
of Vital Records,	e 2.0	Completed			24a. Was an autopsy performed?					
Vita	Attending Physician: r death. ector: After this certifica by the funeral director.	Be	25. Was case referred to medical examiner?	26. Place of Death						
of	Physic rthis oral dir	. To	1		e 5 Aesidence 8d. Describe how in	6 ☐ Other (Specify)				
ö	ath. ath. rr: Afte	atlor	27. Manner of Death  1	of 28c. Injury at Work?  M 1 Yes 2 No		,,				
Division	l or Atte atter de Directo I in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	8f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)				
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal (Check only one)  1 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and occurred at the time, date and place, and occurred to the control of the control of the control occurred to the control occurred	nd due to the cause d at the time, date a	(s) and manner as stated. and place, and due to the cause(s)				
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Dey, Year)				
			May & Melore No	7 02/11	7 11	118-12007				
	9+1		30. Name and address of person who completed cause of death (Item 23a) (Type Vijay Nellone. M.D. Pevry Point Medi		int. MD 2	21902				
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	and i						
	negistr	ai	NOV 2 7 2007 Jan 2 Ag							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Rebha Virginia 2007 Bryant /Medical 4c. County of Death Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Munico eninsula Negla na alisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Ade (In vrs. last birthday) 8. Date of Birth **Funeral** Year Days Months Hours 1 M 2 F 213-18-9521 93 Director June 19. 1914 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Mol Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be r 200 Civic Avenue 21804 Funeral within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 M Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) s 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) cafeteria worker Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irving Jett Bryant ဂ Julia Haynie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Gloria Wilson (Sister) 27504 Riverside Dr. Salisbury, Md. 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Roseland Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Nov. 6, 2007 Reedville, Va. 22. Name and Address of Facility Jones-Ash Funeral Home 21. Signature of Funeral Service Licenses 0502900342 Heathsville, Virginia 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Stroke /Medical Due to (or as a consequence of): Examiner Da Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Justice of Light) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-tran Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical the as nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 1 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s performe 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA L<sub>O</sub> this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death, To the Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

SHisbury, Md, 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

relder

2007

Michael

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Year Physician November 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1**⊠**M 2□F Hours 176-62-9709 Director 43 DEC 25, 1963 Pennsylvania Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at 1 ☐ Yes 2X No Director PA York Red Lion 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a or other traumatic event, the Medical Examiner must be 120 Zion Church Road 17356 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important; If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Pressman Printing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Everett Bray Pauline Schaffner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacey Bray/Spouse 120 Zion Church Rd., Red Lion, PA 17356 20b. Place of Disposition (Name of cemetery, crematory or other place)
White Rose
Crematorium 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Important; If it any Injury or o 4 ☐ Donation 5 ☐ Other (Specify) -11/9/2007 York, PA 22. Name and Address of Facility
Diehl Funeral Home & Cremation Center, Inc.
P.O. Box 1031, Mount Wolf, PA 17347 21. Signature of Funeral Service Licenses milne M01508 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Asystule disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Liver Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Caroli's attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I ☐Yes 2☐No the 9□Unknown 9 ☐ Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed certificate Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p

State Registrar

31. Date filed (Month, Day, Year) NOV 07 2007

29b. Signature and title of certifier

Andrew Goins,

Wolfe Street Baltimore, MD 21287-9106 600 North 32 Registrar's Signature

Resident P642

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

DHMH 16 Rav 6/95

State

Registrar

NOV 0 7 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health State Amend PII, 27, perME, 0874, 12/3/07 TT Certificate of Dealth Registrar	ilth and M	ental Hy	giene Reg. No. 2	107	376	57
	Physic		1. Decedent's Name (First, Middle, Last)  Betty Jean Beach		2. Date of Do Month	eath Day	Year	3. Time of De	
	/Medi Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local		Databa	4c. County		1740	M
		À	5. Social Security Number 6. Sex 7. Age (Irl yrs. last birthday) If Under 1 Year If Ur	1		Princ	c 6	Corps S	,n.
i.	Funeral Director		579-42-5678 1 M 2X F 76 Yrs. Months Days Hou	Under 24 Hrs. ours Min.	8. Date of Bi (Month, Da Aug 22	nth ay, Year) 1931	9. Birthp Cour Wash:	place (State or Fo ntry) ington,	oreign D.C
	yland now at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location					10d. Inside City L	
	Ra-fst	Director	MD Prince George's Lanham					1  Yes 2 <b>X</b>	
	3a or 2	le Dir	10e. Street and Number       10f. Zip Code         9749 Good Luck Rd. #10       20706			10g. Citizen of V	What Coun	ntry?	
	er deat items 2 ier mu	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic If Yes specify Cultan Marital Status	nic Origin? (Specexican, Puerto F	cify Yes or No	)- 14. Rad	ce - Americ		
5-0036	should be lited within 72 hours after death with the Maryland And Mental Hygiene. Thygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", so went, the Medical Examiner must be notified at	þ	3 □ Widowed 4 ☑ Divorced   1 □ Yes 2 □ No   1 □ Yes 2 □ No   Spe	ecify:	,		<sup>v:</sup> Whit		
15-0	"natul "natul edical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4cr 54)  If a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	g most of workin	g	16b. Kind of B			
U.	d within giene. er than the M	omp	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		5	Own Hom	ie		
Maryland	ntal Hygie ed other i event, th	Be	17. Father's Name (First, Middle, Last)			Maiden Surnan	ne)		
ary		٦.	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number 19b)	elyn Lou			State 7in	Cadal	
	l and 2 lealth a im 27 is her trau		Donna J. Holly/daughter 9749 Good Luck Rd					Code)	
Baitimore,	rages nent of H ant: If Ne ary or of		20a. Method of Disposition  1 □ Burial 2 ☒ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)		ate	20c. Location -	•	,	
	permit. rages Department of Important: If It any Injury or o		21. Signator of Funeral Service Licensee  22. Name and Address of Factory  Chesapeake Crematory  22. Name and Address of Factoring Home Crematory	y 11/03 Facility	3/07	Beltsvi	<u>lle,</u>	MD	
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P	hysician		23a. Parl . Enter the "isease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ch as cardiac or	respiratory as	rrest,		Approximate Interval Between Onset and Deat	n th
	/Medical xaminer		Due to (or as a consequence of):						
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Political	and -transit	Examine	Inat initiated events C.						
orou,	physician and the burial-transit	dical E	Due to (or as a consequence of):						
X 00 X	ling phy	Medi	IF FEMALE:						
The law requires that the death certific	by the attending parached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date Mor	e of deliver nth [	ry Day Year	
es that	igned b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	Part I.	23e. Did to	bacco use contr	ibute to the	e cause of death	1?
v requir	been sig	eted	Pronie Obstructive Pulmonary Disce	150	1 U Y	es 2 No	3 Proba	ably 4 Unkno	own
The lay	page 2	Completed	chance immobility left femus fracture due to		24a. Was a autop perfor	sy p	Vere autoportion to com eath?	sy findings availa pletion of cause	able
Physician:	certificate rector, pag	Be	25. Was case referred to medical examiner? 26. Pla	Place of Death (			☐Yes 2	2 No	
Phys	al dir	- To				ence 6 DOthe		,	
Attending	er death. rector; After by the funer	Satio	1 □ Natural 5 □ Pending (Month, Day Year) Injury Work?  2 □ Accident investigation with San under the second 1 □ Yes Zi	/ .	و لهر يكومهم		ıu		
lorAt	after d	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		City or I ow		r or Rural	Route Number,	
Hospital			29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, of and manner stated	o and place	d due to the o		ner as sta	uted.	
o the	o the o	Medical	and manner stated.  29b. Signature and title of certifier  29c. License numbe						
_	> = 0					9d. Date signed	Para "	ay, rear)	,
(3)	a2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Solvation Sylvation 3001 Hospital Drive  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Cha	ere	Man	10	of vorc	
	Stat Registra	~	31. Date filed (Month, Day, Year)  NOV 0 8 2007  Septiment 1. Specific 1. Spec		Ur			10 10	3

Ammended # 23c, DLB, 11-13-07, St. Mary's Co Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 21. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Gene Aloysius AM Cusic, Jr. 10:45 November 7, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25132 Three Notch Road Hollywood St. Mary's If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director 213-92-7042 38 April 6, 1969 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25132 Three Notch Road 20636 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2[**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: ð Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Maintenance Veterans Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gene Aloysius Cusic, Sr. Wendy Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Sue Cusic / Wife 25132 Three Notch Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 9, 2007 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signator of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Rome, P.A. P.O. Box 270, Leonardtown, Maryland 20650 Michael 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Failure Physician /Medical Due to (or as a consequence of): Examiner reanic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of): the death certificate be executed burial-trar Dysphagia Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ oha rocepha 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? death? 1 ☐ Yes 2 🕱 No certificate 1∐ Yes Division or Vital 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: Injury 1 X Natural 5 ☐ Pending investigation To the Hosp....
within 24 hours after cear.
To the Funeral Director Aft at or At ending after ceam.

Director Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11.07. 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAE T. AUNG, 24435 MERVELL DEAN RD. HOLLY WOOD, MD 20636 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 13 Z007 Registrar

			State of Maryland / De				/giene		
			negiona.	Certificate of	Death		Reg. No.2	007	37669
l.	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of D	Day	Year	3. Time of Death
COX.	/Medic		SHIRLEY TAYLOR CARTWRIGHT  4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location	OCTOBE		2007 unty of Death	8:45P M
	Examir	er	SOUTHERN MARYLAND HOSPITAL		LITNO			•	GEORGES
Ť.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days	If Under Hours	24 Hrs. 8. Date of Bi	rth av. Year)	9. Birth	place (State or Foreign
	Director		579 52 4553 1 M XX F 68 Yr Usual Residence of Decedent	s. Daye	110010	MAY 12	, 1939	WAS	HÍNGTON, DC
	land ow		10a. State 10b. County 10c. City, Town of	r Location					10d. Inside City Limits
	a-f sh	tor	MD PRINCE GEORGES UPPER	MARLBORO				1	1XXYes 2 □ No
	ith the	Director	10e. Street and Number	10f. Zip Code			10g. Citizen	of What Cou	ntry?
	ath w		10607 WACO DRIVE		772			ED STA	
	items items iner n	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married XX Married  1 □ Yes XX No	<ol> <li>Was Decedent of F If Yes, specify Cub</li> </ol>	Hispanic Or an, Mexica	igin? (Specity Yes or Non, Puerto Rican, etc.)	0- 14.	Race - Ameri Black, White,	
920	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	3 Widowed 4 Divorced Year or Dates:	1 □ Yes 2 <b>XX</b> No	Specify:		Spi	ecify: BI	LACK
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aŭ	ld be ental ked o	To Be	WILLIAM TAYLOR			ES E. BROWN		na.r.o <sub>j</sub>	
Maryland	should and Men s marke	-		lailing Address (Street	and Numb	er or Rural Route Numl	per, City or To	wn, State, Zij	code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at			07 WACO DR		UPPER MARI	BORO,	MD 207	772
altimore,	0 0		20a. Method of Disposition  XXBurial 2 □ Cremation 3 □ Removal from State  20b. Place of D  cemetery,	isposition (Name of crematory or other pla	ce)	Date	20c. Locati	on - City or T	own, State
탪	permit. Pag Department Important: I any Injury once.			NCOLN CEME				TWOOD,	
Ba	permit. Pag Department Important: If any Injury o		21. Signature of Funeral Service Licentee	MARSHALL 4308 SUIT	S FUN LAND	ty ERAL HOME ( ROAD SUIT	OF MARY	ZLAND, MD 207	INC. 746
B			23a. P. o. 1. Enter the disease, or complications that caused the death. Do not size, or heart failure. List only one cause on each line.			cardiac or respiratory a	arrest,		Approximate Interval Between
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ROX	w requires that the death certific been signed by the attending I should be detached for use as	J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy				23d	Date of deliv	env
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	Physician: this certific ral director,	o Be	examiner?  1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpa	atient 3 DOA Oth		e of Death (Check only ursing Home 5 Res		Other (Case)	6.1
סר	ig Phys ter this neral dir	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Tim	ne of 28c. Injur		28d. Describe			
	Attending r death. ector: After by the fune	atio	2 Accident investigation	M 1□	Yes 2□	No			
UIVISION	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury · At home, farm building, etc. (Specify)	, street, factory, office		28f. Location ( City or To	Street and Nu wn, State)	umber or Run	al Route Number,
_	spital ours a neral I		29a. Certifier ertifying Physician: To the best of my knowledge, d	eath occurred at the ti	me date ar	ad place, and due to the	cauca(c) and	l mannar ac s	stated
	n 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/one and manner stated.	or investigation, in my	opinion, dea	ath occurred at the time	, date and pla	ce, and due t	o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. Licens	e number			gned (Month,	• • • • • • • • • • • • • • • • • • • •
)			Newman MD	D6	3183		11	03/0	7-
2	(10)		30. Name and address of person who completed cause of death (Item 23a) (Ty		_	7.70			20735
			VUAY SHRI KANNAN , 7503  31. Date filed (Month, Day, Year) 32. Registrar's Signature	SURRAHTS	R	OAD, CL	MYON	V - MC	20735
	Sta Registr	_	NOV 0 8 2007 Signature 132. Registrar's Signature 14.	1					

			for State	State of Maryland		partmei <i>ertifica</i>			nd Me		2111	17	37670
-			Ragistrar  1. Decedent's Name (First, Middle, La	ctl	U	erunca	ie or l	Jealli	1 2	Re Date of Death	g. No U		3. Time of Death
	Physici	an								Month	Day	Year	
	/Medic		James Will  4a. Facility Name (If not institution, give		Sr.		. Town or	Location of		ovember	4c. County of	007 of Death	4:55 a.m.
	Examin	er	St. Mary's Hosp					nardto			St. M		S
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. I	ast birthda		r 1 Year	If Under 24	4 Hrs. 8.	Date of Birth (Month, Day,			ace (State or Foreign
	Director		5/9-18-2513 - <del>599-18-2513</del> -	X M 2□F 93	Yrs	Months	Days	Hours	Min. 1	2-19-19	913	Mary	land
	D >		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or	Location						1	0d. Inside City Limits
	aryla ehov	ō			,								1 ☐ Yes 2 📉 No
	28a-f	Director	Maryland St. Ma	ry's		Ho11y	WOOd ip Code			10	g. Citizen of W	hat Cour	ntry?
	Se or	0	23837 Tin Top Hi	11 Iano				0636			United		
	ms 2;	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 1	3. Was Dec			in? (Specif	y Yes or No- can, etc.)	14. Race	- Americ	an Indian,
9	or Ite		1 Never Married 2 Married	Armed Forces? 1X1Yes 2 □ No If Yes, Give		1 ☐ Yes		Specify:	rueno ni	an, etc.)		, White, 6 Blac	-
21215-0036	d within 72 hours after death with the Maryland place. Then "neture!; or Items 23e or 28e-f show the Medical Examiner must be notified at	d by	3X Widowed 4 □ Divorced	Year or Dates:									
7	72 h	ete	15. Decedent's E (Specify only highest gr	ducation ade completed)	(G	icedent's Us ive kind of w e. DO NOT	ork done	during most of	of working	1	6b. Kind of Bus	iness/Ind	dustry
12	withir 9ne. then	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	****		cklay	•			Con	stru	ction
N	77 75 2 2		17. Father's Name (First, Middle, Last	)		DLI	CKIA		's Name (/	First, Middle, M	laiden Sumame		CCION
an	ould be Mental Marked c	To Be	John Henry Chas	e				Ca	theri	ne You	ng		
	2 should and Men ie marke eumatic	-	19a. Informant's Name/Relationship		19b. M	ailing Addres	ss (Street				City or Town, S	state, Zip	Code)
	s 1 and 2 should be filed t Health and Mental Hyg Item 27 is marked othe other treumatic event,		Joseph E. Chase	/ Son	13 E	3elmon	t Ave	enue,	Brock	ton, M	A 02301		
Baltimore,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3		lace of Dis emetery, o	sposition (National National N	ame of other plac	:ө)	Dat	e 2	Oc. Location - 0	City or To	own, State
Ĕ	permit. Pages Depertment of I Important: If its eny injury or o		4 □Donation 5 □Other (Speci	(y) Bri	nsfie	eld-Ec	hols	Cr. 1	1-13-	-2007 C1	narlott	е На	11, MD
alt	permit. Depertr Imports eny inje		21. Signature of Funeral Service Lice	nsee Moos	3	-		ss of Facility	DITI				me, P.A.
_	₹0 E € 9		Edward N. Brinsfi	eld. Jr.	2	22955	Holly	wood	Rd.,	Leonard	dtown,	MD 2	0650-0279 Approximate
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.	n. Do not	enter the mo	ode of dyin	ng, such as c	ardiac or r	espiratory arre	SI,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Multi So	Star	- tai	1000						
	/Medical Examiner		1	Due to (or as a consequ	uence of):								
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence of):								
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Hanaly	emic								
ć	te be executed ysician and ne burial-transit		resulting in death) Last	Due to or as a consequ									
760,	ysicia ysicia	cal		a Dic									
68	ntifica ng ph as th	Med	IF FEMALE:										
Вох	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetat	death	3 □Ectopic		/			23d. Date Mon		ery Day Year
	it the death certificat by the attending phy tached for use as th	Physician/Med	1 Yes 2 No	4□Pregnant at time of de 9□Unknown	eath	5 Other (	specify)						,
P.0	Physicien: The law requires that the death certifical this certificete has been signed by the attending phyral director, page 2 should be detached for use as the		Part II. Other significant conditions	contributing to death but not resi	ulting in th	e underlying	cause div	en in Part I.		23e. Did tob	acco use contri	bute to the	he cause of death?
Vital Records,	signe d be	d by		ely Jatron.		, ,	•			1 <u></u> Ye	s 2 🗓 No	3 □ Prot	oably 4 Unknown
Ö	w require been sit should b	Completed		-1/ 02-1						24a. Was ar	24b W	Vere auto	ppsy findings available
Rec	: The lav	m								autopsy	ned? p	rior to coi eath?	mpletion of cause of
ā	icien: Th certificate rector, pag	e Co	25. Was case referred to medical					26 Place	of Death (	1 ☐ Yes 2 Check only one	4.	☐ Yes	2 L No
5	ysicien: is certific director,	To B	examiner?	Hospital: XXInpatient 2	ER/Outpa	atient 3□ [	OOA Oth	05			nce 6 □Othe	r (Specif	<b>(v</b> )
1 0	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	e of	28c. Injur Wor	y at	28	d. Describe ho	w injury occurre	ed .	
Ö	ath. pr: Aft	atio	1 Natural 5 Pending 2 Accident investigation	on	,	.,		Yes 2□N	40				
Division	r Atte	Certification:	3 Suicide 6 Could not determined			, street, facto	ory, office		28	f. Location (Sti City or Town		r or Rura	al Route Number,
	To the Hospital or Attending P! within 24 hours after death. To the Funeral Director: Attent completely filled in by the funeral												
	Hosp 4 hou Fune ely fil	Medicai	(Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina	wledge, d	leath occurre or investigation	ed at the tir on, in my o	me, date and pinion, deat	d place, an h occurred	d due to the ca at the time, da	iuse(s) and mai ate and place, a	nner as s nd due ti	stated. o the cause(s)
	the the the the the the the the the the	Med	one) 29b. Signature and title of certifier	and manner stated.			9c Licens	se number		25	od. Date signed	(Month.	Dav. Year)
	P N S		1/1/har har	Wahd. MI	n		D	360	47	3		0/	07
1			30. Name and address of person who	completed cause of death /from	232) (To	rpe Print)			' /	/	(1/1		- //
6	an		Mehrdad Akhlaghi				ut Ro	oad, L	eonai	dtown.	Maryla	nd 2	0650
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa									
	Regist		N∩V 1 3	2000									

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		•	State Amend Item	State of <b>25 per o</b>	Maryland <b>Ir.,g87</b> 4	d / Depa <b>, 12<u>/</u>2</b> /	rtment of H	lealth a Death	and Mental	Hygie Reg	ene . No D	0.7	37671
127	ysicia Medic	an	Decedent's Name (First, Middle, Cecilia			Clar			2. Date of Month	of Death	Day 13.	Year 2007	3. Time of Death  8:15 a M
	amin	er	4a. Facility Name (If not institution, Charlotte Hall	Veterans	Home		4b. City, Town, or <b>Charlot</b>	te Ha	of Death 111		4c. Count	of Death Mary	's
Fun Dire			5. Social Security Number  577–24–9305  Usual Residence of Decedent	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs. la	ast birthday) Yrs.	Months Days	If Under Hours	Min. (Mont	h, Day, Y	1921	Coui	place (State or Foreign htry) ington, DC
e Maryland la-f show	tified at	Director	10a. State 10b. County	Mary's	10c. City	Town or Loc	cation	1					0d. Inside City Limits 1 ☐ Yes 2 No
with th	t be no		10e. Street and Number  29449 Charlotte	Hall Ros	ad		10f. Zip Code	0622		10g	. Citizen of	What Coul	ntry?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. when than "natural", or items 23a or 28a-f show	caminer mus	by Funeral	11. Marital Status  1★Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Dece Armed For	dent Ever in U.S roes? 2  No e				gin? (Specify Yes on, Puerto Rican, etc.	or No-	14. Ra	ce - Americ ck, White, fy: <b>Wh</b>	etc.
Nore, Maryland 21215-0036 tges 1 and 2 should be filed within 72 hours af nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or	e Medical Ex	Completed b	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		(Give I life. E	ent's Usual Occup kind of work done o OO NOT use retired	during mos i)	t of working		b. Kind of E		·
e filed v If Hygie other t	rent, th	Be Co	12 17. Father's Name ( <i>First, Middl</i> e, <i>L</i>	ast)			Fiscal Cl		er's Name (First, M		U.S. (		nment
Maryland td 2 should be file tth and Mental H;	atic ev	To B	Edward	Franc	cis		lark		ıry		Agnes		Wright
and 2 sh ealth and n 27 is m	r traum		19a. Informant's Name/Relationshi Thomas D. Clark		other	Ī			er or Rural Route N . <b>, Charlo</b>				,
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 27 i	ury or othe	-	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other ( <i>Sp</i>		State C6	emetery, cren	sition (Name of natory or other place <b>Veterans</b>		Date .1/26/200	- 1	c. Location		
Balt permit. Departr Importa	any inj once.		21. Signature of Furieral Service	gensele ON -		Br	Name and Addres	-Echo	ls Funera	al He	ome, 1	P.A.	, MD 20622
cate be executed wax Employers and modern and beautiful possible.	iner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (	or as a consequence or a consequence or a consequence or a consequence or a consequenc	ence of):  ONDS ence of):	v's d	em:	entia				,
I Records, P.O. Box 68: The law requires that the death certificat ate has been signed by the attending phy	SB	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Live b	come pf pregnal irth 2 □ Fetal ant at time of de own	death 3	Ectopic pregnancy Other (specify)	,				ate of deliver	ery Day Year
rds, P. quires that in signed by	pe	þ	Part II. Other significant condition	ns contributing to de		Iting in the ur	derlying cause give	en in Part I		Did tobad	2 No	tribute to t 3∏ Prol	he cause of death?
or Vital Records, Physician: The law requires trhis certificate has been signe	N	Completed								Was an autopsy performe es 2		prior to co death?	opsy findings available mpletion of cause of
Vision Attending r death.	in by the	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Activate 5 Pending investige 3 Suicide 6 Could no determines.	28a. Date of (Mont) stion at be 28e. Place	of Injury h, Day Year)	ER/Outpatien 28b. Time of Injury me, farm, stre	28c. Injur Worl	er: 4 <b>1</b>	No 28f. Locat	Resident	injury occu	rred	iy) al Route Number,
ospita hours ineral	y filled	edical Ce	29a. Certifier (Check only one)	Physician: To the xaminer: On the ba and manr	best of my know asis of examinat ner stated.	wledge, death ion and/or inv	occurred at the tir vestigation, in my o	ne, date ar ppinion, dea	nd place, and due that he at the	o the cau time, dat	se(s) and me and place	nanner as s , and due t	stated. o the cause(s)
within 24 To the Fu	dwoo	Me	29b. Signature and title of certifier	San	mz		D4:	509	2	1	Date sign	12	007
t fr	Sta	te	30. Name and address of person of the solid land	Koa	e of death (Item	ite	205	Pu	ince F	rec	levi	ch	MD 2067
Re	gistr	1	NOV 16	2007	me H	ho	ells ?						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER Day 200 Year **Physician** 11:46 Am CURRY BERTHA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE"S CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖳 F 578-32-1503 Director AUGUST 15 1926 VIRGINIA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD PRINCE GEORGE'S CAPITOL HEIGHTS 1 Yes 2 No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 7313 WALKER MILL ROAD 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: BLACK ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th DOMESTIC PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BERTHA CARRIE WOOD JACOB JESSIE JAMES HENDERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7313 WALKER MILL ROAD CAPITOL HEIGHTS, MARYLAND 20743 KENNETH D. CURRY SR./HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MD VETERANS CEMETERY 11/16/2007 CHELTENHAM, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner GI BLEED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit the death certificate be executed ACUTE RENAL FAILURE Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as led by the attending detached for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 2 Fetal death in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death □Yes 2□No 9□Unknown 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No 24a. Was an autopsy performed? 1∐ Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 Yes 2 No ို 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Naturai Iniury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🛴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated -29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8416 Central Avenue Landover, Maryland 20785 Ophnell Cumberbatch M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 9 2007 Registrar

P.O. Box 68760 Records.

Baltimore, Maryland 21215-0036 **Physician** Examiner Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Certification: RN, Silver Spring mD 209 (19)

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and makiner as stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaiser Hospitalists, 1500 Forest Glen Road, Silver Spring, MD Shailesh Sheth, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month <sup>Day</sup> 2007 Boone Chandler Thomas 06 Nov 01:45PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 14952 Day Road Goldsboro Caroline 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1**X** M 2 □ F Director 72 412-50-8586 Usual Residence of Decedent Sept 25 1935 Virginia 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ⊓s 23a or 28a-f sh ⊓ust be notified Maryland Caroline Director 1 ☐ Yes 2 ☐ No Goldsboro Pages 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.
snt: If Item 27 is marked other than "natural", or items 23a or 28a.
ury or other traumatic event, the Medical Examiner must be notif 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14952 Day Road 21636 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vice President: production box manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Roy Chandler ٩ Nora Belle Boone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Lou Chandler; wife 14952 Day Road; Goldsboro, Maryland 21636 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important: If Ite any Injury or ot 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery 11/12/07 Greensboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

No not enter the mode of dying, such as cardiac or respiratory arrest,

Interval Betw Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) une 6 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a connequence of) Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year signed by the at d be detached for 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 No After this certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 2 Accident 6 Could not be 3∏ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature a d title of certific 29d. Date signed (Nonth, Day, Year)

State

Registrar

31. Date filed (Month

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DR. Su 302

cause of death (Item 23a) (Type, Print)

Begistrar's Signature

2007

DHMH 17 Rev 1/2001

State Registrar

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		. For	State of Marylan	d / Department of I Certificate of		, ,	0007	07676
		1 State Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of		Reg. Note of Death	6001	3. Time of Death
Physic		Ross T Ca	rter Sr	-	↑ Mo	tooth Der	Day Year	71635 M
/Med Exami		4a. Facility Name (If not institution, give st	reet and number)	Ab. City, Town,	or Location of Death	4	c. County of Deat	n
		5. Social Security Number 6. Sex	HOSOITAL 7. Age (In yrs. I	last birthday) If Under 1 Year	If Under 24 Hrs. 8. Da	te of Birth	Kent	hplace (State or Foreign
Funeral Director		220-09-4890	7. Age (In yrs. i	Yrs. Months Days	Hours Min.	te of Birth o <i>nth, Day, Yea</i> /7/1922	ar) Co	MD
pu »		Usual Residence of Decedent  10a. State 10b. County	10c City	y, Town or Location				10d. Inside City Limits
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	tor	MD Queen Anr		hestertown				1 ∐Yes 2 No
ith the or 28a	Funeral Director	10e. Street and Number		10f. Zip Code		10g. 0	Citizen of What Co	untry?
sath w	eral	119 Darden Rd.	2 Was Decedent Ever in II	21620		an ar Na	USA 14. Race - Ame	rican Indian
fer de	Fune	11. Marital Status  1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U. Armed Forces?  12 Yes 22 16 /8/ Year or Dates:	If Yes, specify Cub	Hispanic Origin? (Specify Yo pan, Mexican, Puerto Rican,	etc.)	Black, White	e, etc.
ral", or	þ	3X Widowed 4 ☐ Divorced	If Yes, Give 11/8/ Year or Dates: 2/6/	45   1 □ Yes 2 <b>X</b> No 47	Specify:		Specify: W	hite 
72 ho "natu	Completed	15. Decedent's Educa (Specify only highest grade	ation	16a. Decedent's Usual Occu	pation during most of working ed)	16b.	Kind of Business/	Industry
within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	Meat Cutt		s	upermark	e <b>t</b>
e filed al Hygi other vent, i	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (First		en Surname)	
ould bound by Menta	70	Charles Carter			Bessie Sm:			
12 sho h and 7 Is m traum		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailing Address (Stree				lip Code)
tem 2		Ross Carter/Son  20a. Method of Disposition	20b. F	119 Darden R Place of Disposition (Name of cemetery, crematory or other place)	Date		Location - City or	Town, State
Page nent of nt: If i		1 ABurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		ly Hill Mem. G	arden 11/3/0		ltimore,	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur. any injury or other traumatic event, the Medical ponce.		21. Signature of Funeral Service Licenses	2/11/-		ess of Facility Fellow Rd. Chesterto			& Newnam
7 70 E 8 9		23a. Part1. Enter the disease, or complic	fletgebla				21020	Approximate
Dhysisian		Immediate Cause (Final	e cause on each line.					Interval Between Onset and Death
Physician /Medical	н	disease or condition resulting in death)	Due to (or as a conseq	uelice of):	with Hxpox.	ia		
Examiner		Sequentially list conditions, b.		PNEMOWA	with Sepsis			
ted nsit	kaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the area of the	struction Pul				
executed n and ial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):	kirkung der	eure_		
The law requires that the death certificate be ex the has been signed by the attending physician or page 2 should be detached for use as the burial	ical	d.						
n certifica anding pl use as t	Physician/Medical	IF FEMALE:	c. If yes, outcome pf pregna	ancy			004 D-46 4-9	
death a attenual for us	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3 ☐ Ectopic pregnan	су		23d. Date of del Month	Day Year
that the de led by the	hysi	9 Unknown	9□Unknown					
res tha igned be de	by P	Part II. Other significant conditions conf			iven in Part I. 2	3e. Did tobacc		the cause of death?
w requires to been signer should be	Completed	- Chang Traffel	inpection	~				
The lav	ldmo					4a. Was an autopsy performed	?   death?	utopsy findings available completion of cause of
	Be Cc	25. Was case referred to medical			26. Place of Death (Che	☐ Yes 2 📶 I ck only one)	No 1 ☐ Yes	2 □ No
Physician: r this certifica ral director, p	To B	I Tes Ze No		Elfouthatient 3 DOA	her: 4 Nursing Home			cify)
ing ing	ion:	27. Manner of Death  1  Natural 5  Pending  2  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inju Injury M 1 1	uryat 28d. D ork? ]Yes 2 □No	escribe how in	njury occurred	
Attending r death. ector: After by the fune	ficat	3 Suicide 6 Could not be	28e. Place of injury - At ho	ome, farm, street, factory, office	28f. Lo	cation (Street	and Number or R	ural Route Number,
tal or s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specif	у)		ity or Tòwn, St	ate)	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: ¢ completely filled in by the t	edical	(Charleson Collaboration)	and On the boards of accomplish	owledge, death occurred at the ation and/or investigation, in my	and the large of a path of a programmed and	the endinger of each	and alone and the	- A - Al (-)
To the within 2 To the comple	Med	29b. Signature and title of certifier	and marrier stated.	29c. Licer	se number	29d. I	Date signed (Mont	h, Day, Year)
5		D. C. Bush	al In M. O	). 02	23889	/	11/1/07	7
10: 0		30. Name and address of person who cor	mpleted cause of death (Iten	29c. Licer D 2 n 23a) (Type, Print) 22 3 1/4 2/4 2/4 ature	aut out	10.0	711-1 -1	670
m s	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	- CIPPICA	round	mu 21	Y ===
Regis		NOV 0 5 2	2007	De Aposte				
HMH 17 Rev 1	2001		<b>F</b>	•				

Registrar DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month ATHERINE OCTOBER 29 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) HESTERTOWN 24 Hrs. 8. Date of Birth IUER 1 Year | If Under Date of Birth Month, Day, Year) 8/19/1939 Birthplace (State or Foreign Country) Months Days 1 □ M 2 K F Hours 222-22-8796 68 DE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County X Yes 2 □ No MD Kent Rock Hall 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5689 Main St. 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2\( \overline{\text{D}}\) No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo White Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Head of Order Entry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond C. Morris Nancy M. Clough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Coleman/Son 21251 Kansas Ave. Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Wesley Chapel 11/2/2007 Rock Hall, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam 21. Signature of Funeral Service Licenses 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 3c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

Completed by

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

this After

or Attending Physician: The law requires that the death certificate be executed

To the Hospitai

Division or Vital Records, P.O. Box 68760,

Examine by Physician/Medical Completed Be P Certification: 

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2
Part II. Other significant condition	ns co
7100	٧.
25. Was case referred to medical examiner?	eg
27. Manno of Death  Natural 5 ☐ Pendin  2 ☐ Accident investig	

and L	محا	Quí,	_
ions contribu	uting t	o deat	h
1			

23e. Did tobaco	co use con	tribute to the cau	se of death?
1. Yes	2 □ No	3 ☐ Probably	4 □Unknov

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) License number d title of cert

28c. Injury at Work?

o completed 30. Name

6 ☐ Could not be

determined

2060301

State Registrar

Medical

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

29b. Signatur,

4 Homicide

(Check only one)

32. Pagistrar's Signature

1 Inpatient

(Month, Day Year)

28a. Date of Injury

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

0

10+

Registrar

eclerick 31. Date filed (Month, Day, Year)

29b. Signature and title

30. Name and address

of person who completed cause of death (Item 23a) (Type, Print) MD 6602

Church Hill Rd. Chestertown, MD 21620

29d. Date signed (Month, Day, Year)

32. Registr 's Signature

Delboy,

29c. License number

D5 1735

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

ORIGINAL

Assistant Medical Examiner

2007

0 9 Name and address of person who completed cause of death (Item 23a)

09

Laron Locke MD

31. Date filed (Month, Day, Year)

**OCME** 

32. Resistrar's Signature

111 Penn Street, Baltimore, MD 21201

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 or Attending within 24 hours a er dear To the Funeral Director: completely filled in by the Hospital

Baltimore, Maryland 21215-0036

Medical

State Registrar

NOV 2

29b. Signature and title of certifier

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32 Registrar's Signature

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 3, 2007 Lourdes V. Clarens Nov. 3:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5908 Lenox Road Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 89 Cuba 261-72-3217 Director June 5,1918 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show r 28a-f show notified at 1 X Yes 2 ☐ No Director Md. Montgomery Bethesda 10e. Street and Number 10g, Citizen of What Country? 10f. Zin Code than "natural" or items 23a or the Medical Examiner must be 5908 Lenox Road 20817 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" --- any injury or other traument. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Cuban White 14 Yes 2□No Specify: Specify: \$ 3 ☑Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rene Valverde Maria de la Concepcion Grau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angel F. Clarens/Son 4320 Klingle Rd., NW., Washington, DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐Removal from State Metropolitan Crem. 4 □ Donation 5 □ Other (Specify) Nov.5.07 Alexandria, Va. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Liourse 2222 Wisconsin Ave., NW., Washington, DC 20007 23a. Part1. Enter the disease, or complications if a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gaus in each line. immediate Cause (Final Cardiac Arrest **Physician** Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerotic Cardiovascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f ☐Yes 2 No 9 Unknown 9 Unknown s been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has to page 2 s autopsy performed? certificate 1 Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပို After this 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 29256 November 5, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Α. Qu1 yos, M.D., 4343 Montgomery Ave., Bethesda, MD. 20814 32 Registrar's Signature 31. Date filed (Month State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Patty Lee Dean November 10, 2007 8:33 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Nursing Facility Prince Frederick Calvert Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Director West Virginia 03/16/1935 233-50**-**1381 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mines have once. 10c. City, Town or Location 10a, State 10b. County 10d, Inside City Limits 1 ☐ Yes 2 X No Directo Maryland St. Mary's Clements 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22881 Cricket Lane 20624 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: 3 ☐ Widowed 4 🎇 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Optical Specialist Optometry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Levi Adkins Garnet Clay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sean Powell/Son 22881 Cricket Lane, Clements, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Charles Memorial Cem 11/15/2007 | Leonardtown, Maryland 21. Signature Funeral Service Licen 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underh in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine and the burial-trai Due to (or as a consequence of): attending physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been sign page 2 should be OBSTRUCTIUE LUNG 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ONGESTIVE HEART Was an autopsy performe certificate 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Xo 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 5 Pending investigation

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death

> State Registrar

within 24 hours a

completely

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature anghtitle of certifier

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Wisniewski, M.D.

Day, Yea 2007

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MD.

1 ☐ Yes 2 ☐ No

040370

110 Hospital Road, Prince Frederick, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11, November 2007 Lynn Dennis 11:25 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner St. Mary's 24208 North Patuxent Beach Road California If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 F Director 249-13-8868 0klahoma 2-2-1958 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director St. Mary's California Maryland 10f. Zip Code 10g. Citizen of What Country? 0 Items 23a 24208 North Patuxent Beach Road 20619 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 'natural", or 1 ☐ Yes 2 🛣 No Specify: White Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Veterinary Technician h and Mental Hygie Veterinary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Gordon Smith <u>Antonia Shirah</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. Jennifer Renea Dennis/ Daughter 24208 North Patuxent Beach Road, California, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cr 11-16-2007 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service License Kyle S. Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Due to (or as a consequence of): Physician/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
Part II. Other significant conditio	as contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 😘 es 2 🗆 No 3 🗇 Probably 4 🗇 Unknown
	24a. Was an autopsy performed?  1 ☐ Yes 2 ☑ No  24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No
25. Was case referred to medical examiner?	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 ♣No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investig.	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  1   Yes 2   No   28d. Describe how injury occurred
3 Suicide 6 Could n 4 Homicide determin	
29a. Certifier 1 Certifying	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

H0055751

29d. Date signed (Month, Day, Year)

11-15-07

State Registrar

within 24 hours a To the Funeral I

Medical

29b. Signature and title of certifier

Jennife

30. Name and addres person who completed cause of death (Item 23a) (Type, Print) Schmidt, D.O., 40900 Merchants Lane, Leonardtown, Maryland 20650

and manner stated.

31. Date filed (Month, Day, Year)
NOV 1 6 2007

		_	<b>e Type or Print in E</b> State of Marylan					•	
	•	For State Registrar		Ce	rtificate of De			No2007	37684
Physicia /Medic	an	Decedent's Name (First, Middle, HAROLD	S	DOUG		/	2. Date of Death Month Volumber	Day Year 7	3. Time of Death 7:59PM
Examin	er	4a. Facility Name (If not institution, g  DOCTORS HOSP)			4b. City, Town, or Loc LANHAM	cation of Death		4c. County of Death	ORGE'S
Funeral			. Sex		If Under 1 Year If	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign
Director		212-15-8290 Usual Residence of Decedent	81	Yrs.				ll JAM	AÍCA
iryland show	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
the Ma 28a-f s	ecto	MD PRINCE  10e. Street and Number	GEORGE'S	LANHAM	10f. Zip Code		10r	. Citizen of What Co	1 Y Yes 2 □ No
th with 23a or ist be r	Funeral Director	9123 SHERIDAN S	STREET		20706			USA	
tems term	uner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Spec Mexican, Puerto F	eify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	d 1 □ Yes 2 🕅 No If Yes, Give Year or Dates:		1 □ Yes 2 🎇 No S	Specify:		Specify: BI	ACK
"natur	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occupatio kind of work done duri DO NOT use retired)	on ing most of workin	9 1	6b. Kind of Business/	ndustry
l within jiene. r than the Me	ошо	Elementary/Secondary (0-12) 8th	College (1-4or 5+)		ER OPERATOR			PRIVA	TE
be filed tal Hyg d other svent,	Be	17. Father's Name (First, Middle, La	•			3. Mother's Name		·	
d Menid I	ဥ	FERNANDO DOUGLA  19a. Informant's Name/Relationship		19h Maili	ng Address (Street and	ROSA	JOHNSON		in Code)
and 2 s alth an 27 Is er trau		PAULETTE WALTO		9123	,		,	ARYLAND 2	' /
ges 1 at tof He If item		20a. Method of Disposition  1X Burial 2 □ Cremation 3	20b.	Place of Dispo cemetery, cre	osition (Name of matory or other place)	D	ate 20	c. Location - City or	Fown, State
nit. Parantmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lie			COLN CEMETE  2. Name and Address of		a de	RENTWOOD, M NKINS FUNE	
Depril Impo	4	1 X.D.M_	hall		7474 LANDOV				
Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final	nly one cause on each line.				respiratory arres	t,	Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consect by Acute	quence of):	A. C			-	years
Examiner	-	Sequentially list conditions,	b. Acute	AVVIL quence of):	thmin				minutes
cuted Id ransit	Examiner	ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
be executed sician and burial-transit	al Ex	resulting in death) Last	Due to (or as a consec	quence of):					
ificate g physi	edica		d		10 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -				
siclan: The law requires that the death certificate certificate has been signed by the attending phys rector, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet	al death 3[	□Ectopic pregnancy			23d. Date of del Month	ivery Day Year
the dea	ıysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5[	Other (specify)				
ss that gned by	by Ph	Part II. Other significant condition	s contributing to death but not res	sulting in the u	ınderlying cause given i	in Part I.	23e. Did toba	cco use contribute to	
require een sig hould b				-			1 🗆 Yes		
The law rate has b page 2 s	Completed					_	24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of
	Be Co	25. Was case referred to medical examiner?			26	6. Place of Death		Mo 1 ☐ Yes	2 🔀 No
shys al di	은	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	R/Outpatie			ne 5 Residen	ce 6 Other (Spe	cify)
nding th. r: After e funer	tion	1 □ Natural 5 □ Pending 2 □ Accident investiga	(Month, Day Year)	Injury	Work?	s 2 No	ad. Describe nov	injury occurred	
or Atter after dea Director in by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		nome, farm, st ify)	reet, factory, office	2	8f. Location (Stre	eet and Number or Ri State)	ıral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	al Cel	29a. Certifying	Physician: To the best of my kn	owledge, dea	th occurred at the time,	date and place, a	and due to the car	use(s) and manner as	stated.
Fo the Hospital within 24 hours and for the Funeral completely filled	ledical	one)	xaminer: On the basis of examin and manner stated.	ation and/or in					
To To	Σ	29b. Signature and title of certifier	D.		29c. License no	1446	29	d. Date signed (Mont	
		30. Name and address of person w	ho completed cause of death (Ite	m 23a) (Type				11/7/0	
20		Skuen Remse	n 575 Main	Stree	et Suik 3	351 , h	aurel,	MD. 20	707
Sta Registr		31. Date filed (Month, Day, Year) NOV 0 9 2007	the completed cause of death (Ite 20 575 Main 32. Registrar's Sign	Opente	7				

**Physician** /Medical Examiner Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Relocate  23a. Part1. Enter the disease, or comp	plications that caused the dea		. Main St.,			Approximate			
	shock, or heart failure. List only in Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	VD				Interval Bety Onset and D			
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	b			1.55					
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 Live birth 2 Fet 4 Pregnant at time of	al death 3□Ectopic	pregnancy (specify)		23d. Date of de Month	livery Day Y			
Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to									
	24a. Was an autopsy prior to death?  1 ☐ Yes 2 ☑ No 1 ☐ Yes									
Be	25. Was case referred to medical examiner?				eath (Check only one)					
2	T⊠Yes 2□ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ₹ Residence	6 □Other (Spe	ecify)			
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work?	28d. Describe how in					
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Street City or Town, St		ural Route Numb			
Medical (	29a. Certifier 1 Certifying Phyone 2 Medical Exam	nysiclan: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date and pla- ion, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)			
(I)	29b. Signature and title of certifier	/ /		29c. License number		Date signed (Moni				
Me	30. Name and address of person who	ywww. Mr. Completed cause of death (Itel) WSKingMr. D	2	1007928	2	// -/				

DHMH 17 Rev 1/2001

		For State Registrar	State of Maryland / Dep	ertificate of Death	Mental Hygien	Z $U$ $U$ $I$	37685
Tr E		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
Physici		Tayonh W	illiam Dunst. Ir.		November 4		10:32 P M
/Medio Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Deat		c. County of Death	
Examir	ier			Denton		Caroli	ina
	100	Caroline Nursing H		) If Under 1 Year If Under 24 Hrs	8. Date of Birth	Q Riet	hplace (State or Foreign untry)
Funeral Director			M 2□F 86 Yrs.	Months Days Hours Min.	August 19,	1921 Pc	untry) ennsylvania
	1	Usual Residence of Decedent			magasa 17)	172112	rusgevarea
land ow		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
Mary	ō	Maryland Caroline	Woodle	ina		ļ	1 □ Yes 2√⊡ No
the 288	Director	10e. Street and Number	woodaa	10f. Zip Code	10g. C	itizen of What Co	untry?
with so or			/ 2/	21797	11-14	and State	es of Ameri
ours after death with the Maryland ral', or Items 23a or 28a-f show Exercites trans by tradilised at	Funeral	3380 Jennings Chap	2. Was Decedent Ever in U.S. 13.			14. Race - Ame	
	'n	1 Never Married 2 Marned	Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	o Rican, etc.)	Black, White	
within 72 hours after ene. than *natural', or Ite	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ②CNo Specify:		Specify:	uucasian
be filed within 72 hours ital Hygiene. Id other than "natural", i event, Ine Medical Exe		15. Decedent's Educ		edent's Usual Occupation	16b.	Kind of Business/	
n 72	Completed	(Specify only highest grade	completed) (Giv	e kind of work done during most of wo DO NOT use retired)	rkina		eronautics
with than	m	Elementary/Secondary (0-12)	College (1-4or 5+)	1.4			Administrat
Hygie Hygie other	Ö	17. Father's Name (First, Middle, Last)	4	Administrator 18. Mother's Na.	ne (First, Middle, Maide		una use car
	Be						
should be and Menta markad umatic ev	မ	Joseph William  19a. Informant's Name/Relationship (Tyg		ling Address (Street and Number or Ri	via Peterso		Zio Cadol
2 2 2 2	1 .5						
~ ~ ~ ~		Herman C. Dunst	Son 10 A	North Marle Avenue		l'(ary Lana Location - City or	
0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State cemetery, cre	ematory or other place)			
Pages ment of ant: If it	١.,	' 4 ☐ Donation 5 ☐ Other (Specify)	Capitol	3	/2007 Dov		
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	9/	22. Name and Address of Facility loone Funeral Home 2 South Second St	. P A.		
89 = 9	X 15	* Kaulopy	1 hour 1	'2 South Second St	reet, Dento	n. Maryl	land 21629
		23a. Part . Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not el	nter the mode of dying, such as cardia	or respiratory arrest,		Approximate Interval Between
Physician		Immediate Cause (Final	5370 1000	CONCE			Onset and Death
/Medical		disease or condition resulting in death)	Due to or as a consequence of):	Caso	-/		6/10/001
Examiner							
to the section	er	Sequentially list conditions if any, leading to immediate	Due to (or as a consequence of):				
uted d ansit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
exec n an	Exa	resulting in death) Last	Due to (or as a consequence of):				
icate be executed physician and s the burial-transit	dical						
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edic						
leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy			23d. Date of del	livery
leath atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
y the	ysi	9 Unknown	9 Unknown				
res that the de signed by the a be detached f	y P	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
uires sigr Id be	d by				1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Dunknow
w require been signal	Completed				24a. Was an	24h Were au	utopsy findings availabl
has ge 2	E D				autopsy performed?	prior to d	completion of cause of
					1□ Yes 2□N		2 □ No
cian Sertifi ector	Be	25. Was case referred to medical examiner?	ognital:	Other	ath (Check only one)		
hysi this c	2	1 1 162 5 140	ospital: 1   Inpatient 2   ER/Outpatie		fome 5 Residence		cify)
ng F dter uner	0	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time	Work?	28d. Describe how inj	ury occurred	
Attending Physician: or death. actor: After this certification by the funeral director.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Tyes 2 No			
after death after death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Ru ite)	ural Route Number,
ital c rs af rai D led ir					,		
Hospita 24 hours Funeral	cai	29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, dealer: On the basis of examination and/or:	ath occurred at the time, date and place	e, and due to the cause(	s) and manner as	s stated. a to the cause(s)
To the Hospital or Attend within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical	one)	and manner stated.				
With To	2	29b. Signature and title of certifier		29c. License number		ate signed (Monti	
		, james	> sector	4DD 3137	0 11-	.50	
	1	30. Name and address of person who co	mpleted cause of death (Item 23a) (Type	a, Print)	CCX	sto	1,216,29
		James Dic	Les 920	Market	St De	Mol	U 700
	ate	31. Date filed (MoNOV, Year 200	32 Registrar's Signature	and .			
Regist	rar	0 200	The state of the s				

	4	State of Maryland / Department of Health and	d Ment	al Hygie	ene	
		= State Registrar Certificate of Death	0.0	Reg.	No. 2007	37687
Physicia		1. Decedent's Name (First, Middle, Last)	M	onth	Day Year	12:31 A M
/Medica Examine		Stevie L. Dean  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De		10	4c. County of Dear	
Examine	•	University of Maryland Med. Ctr. Bathimore			Baltimo	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 House   Months   Days   Months   Mon		ate of Birth fonth, Day, Y	ear) 9. Birt	hplace (State or Foreign
Director		214-68-3964 AW 201 52 Yrs.		5 13.	55 MI	
land ow	-	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
with the Maryland a or 28a-f show be notified at	٥	MD Queen Annes Centreville				1 □ Yes 🏋 No
th the or 28%	E E	10e. Street and Number 10f. Zip Code		'	. Citizen of What Co	ountry?
ns 23a o	ra L	311 Hackett Rd 21617			USA	
al", o	by Fur	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Mo If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	? (Specify Y uerto Rican	es or No- , etc.)	14. Race - Ame Black, Whit Specify: Bla	e, etc.
n 72 ho "natur	Completed	15. Decedent's Education (Specify only highest grade completed)  [Give kind of work done during most of life. DO NOT use retired)	working	16	b. Kind of Business	/Industry
d withing a spene.	E	Elementary/Secondary (0-12) College (1-4or 5+) Laborer		Ge:	neral Mo	tors Inc
e filec al Hyg othe vent,	Re C	(,,,	,		iden Surname)	
ould b Ments arked artic e	2		y Ja			
and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationship (Type. Print)  Crystal Dean-Wife  19b. Mailing Address (Street and Number or 311 Hackett Rd Co	entr	evill	e, MD 21	617
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natu any Injury or other traumatic event, the Medical once.		20a. Method of Disposition  1 XBurial 2 □ Cremation 3 □ Removal from State  ABounding 5 □ Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Male & Female	0/27	/07 B	urrisvi	lle, MD
permit. Departimontimontimontimontimontimontimontimon		21. Signature of Funeral Service Licensee (W00026) Service 821 W.	enne St A	th Wa nnapo	lley Fur lis, MD	21401
Physician /Medical		23a. Fart1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)				Approximate Interval Between Onset and Death 3 hrs.
Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Exter Uncertains Cause (Disease or injury that initiated events				Imo.
icate be executed physician and s the burlal-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):				
ficate be	edical	d				
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)			23d. Date of de Month	elivery Day Year
that ned by deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	2	23e. Did toba	cco use contribute t	o the cause of death?
quires en sig	g pa	End-Stage Renal Disease	_	1 ☐ Yes	2 <b>₽</b> No 3□P	robably 4 Unknown
ne law re has bee ge 2 sho	Completed	Hypertension	_   2	24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
n: Th fficate or, pag		25. Was case referred to medical 26 Place of		I∏ Yes 2	No 1 □Yes	s 2 No
ysicia s cert directe	o Be	examiner?		<i>eck only one)</i> 5 □ Residen	ce 6 ☐Other (Spe	acify)
ding Phy h. After thi funeral	- 4	27. Manner of Death  1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 4 Work? 2 Accident investigation  28a. Date of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No	28d. I		injury occurred	3011)
tal or Atten s after deat al Director: ed in by the	Certification:	2   Rccider   6   Could not be determined   28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. L	ocation (Stre City or Town,	eet and Number or F State)	Bural Route Number,
ne Hospit 24 hour 18 Funer pletely fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	place, and d occurred at	lue to the cau the time, dat	use(s) and manner a te and place, and du	s stated. le to the cause(s)
	Ž	29b. Signature and title of certifier  29c. License number  AU4174435 M	18310		d. Date signed (Mon	
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			Oct. 19	,2007
m_5		Augusta whitney 22 S. Greene Street, Baltin	mare	MD	21201	
Stat Registra		31. Date filed (Month, Day, Year)  OCT 2 3 2007				
HMH 17 Rev 1/20	04					

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

2007

Melissa Brassell, MD

31. Date filed (MAN) Pay Year

32. registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Davis Louise Ruth <u>7:10</u> ₽м 11-05-2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Brandywine 15230 Regina Dr. If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 11-19-1942 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 N 64 **Director** 213-40-8778 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Director Maryland Prince Georges Brandywine 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20613 USA 15230 Regina Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor KMart 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ William T. Davis Louise <u>Washington</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Sewell/ Daughter 15551 Covington Rd. Brandywine, Maryland20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection 11/14/2007 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Agams Funeral Home PA lug 20605 Aquasco Rd. Aquasco, Maryland 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician META STATIC /Medical Due to (or as a consequence of): **Examiner** SEP515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) 416¢ France the attending physician and hed for use as the burial-tran Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) e Hospital or Attending P 24 hours after death. e Funeral Director; After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5000ANH -0 11-6-07 20010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irving St. N.W. Site 4-BI William MU 110 31. Date filed (Month, Day, Year) State NOV 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 9 **Physician** 2007 4:30 A M Martin Darby /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Vear 1 ☑ M 2 ☐ F 86 Yrs 213-12-1116 21. 1921 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2508 Coach House Way 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, the Lonce. U.S. Government 12 Planner & Estimator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samue1 W. Darby Hallie Mae Lindsay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2508 Coach House Way, Frederick, Maryland 21702 Madalean B. Darby - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 ☐ Donation Providence Cemetery Nov. 14, 2007 Kemptown, Maryland 21. Signature of Fulleral Service Licens 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home hourt 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Res **Physician** pincoony disease or condition resulting in death) /Medical Examiner 3105+ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Division or Vital Records, P.O. Box 68760. Physician/Medical as 1 signed by the attending particles of the detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2√No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 'No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D0064910 Jondes

State Registrar 31. Date filed (Month, Day, Year) NOV 1 3 2007

Pratima Pandey M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West 7th Street, Frederick, Maryland 32. Registrar's Signature

		for State Registrar	State of	Maryland		artment of F rtificate of i		-	giene 0	07 37691
Physic	·ian	1. Decedent's Name (First, Middle	, Last)			·		2. Date of De Month		3. Time of Death
/Med		Britten	Walter		Eak				er 12,	
Exami	iner	4a. Facility Name (If not institution  Charlotte Hall	_				r Location of Death		4c. Count	7.1. ·
Funeral		5. Social Security Number		7. Age (In yrs. In	ast birthday)	If Under 1 Year	otte Hall If Under 24 Hrs.	8. Date of Bir	th	Mary's  9. Birthplace (State or Foreign
Director	_	154-10-3794	1 <b>▼</b> M 2□ F	87	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) <b>6,1920</b>	Pennsylvania
pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
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ter ter	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marri 3 ₩ Widowed 4 □ Divorced	Armed For	2 □ No e		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		ce - American Indian, ick, White, etc.
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2 should be to and Mental is marked or raumatic eve	ြင	19a. Informant's Name/Relationsl		акег	19h Mailin	g Address (Street	E11a		Weave	
tra tra		Marie A. Madden								MD 20695
Definition of the permit. Pages 1 and 5 Department of Health Important: if Item 27 any injury or other transce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State ce	emetery, cren	sition (Name of natory or other place	í	Date 4/2007		- City or Town, State tte Hall, MD
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service		3			11/1			P.A. Hail, MD 20622
certificate be executed Continued by the continued by the		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (	or as a consequence of	ence of):	ARTE DEPER PIDE RRYT	ERY	DISE I	ASE	Approximate Interval Between Onset and Death
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The law requires that the death ate has been signed by the atter age 2 should be detached for u.		Part II. Other significant condition	ins contributing to de	ath but not resul	Iting in the ur	iderlying cause give	en in Part I.		obacco use con res 2 No	tribute to the cause of death?
cian: The law entificate has b ector, page 2 st	e Completed by	My Per Ga 25. Was case referred to medical	stric	ulce	er 1	histor	4 6 Place of Dea	24a. Was autor perfo	osy rmed? 2 <b>X</b> No	Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
ng Physici ter this cer	n: To B	examiner? 1 Yes 2 No  27. Manner of Death	28a. Date o		ER/Outpatien 28b. Time of Injury		er: 4 Nursing H	ome 5 Resid	dence 6 □Ot	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1  Accident 5  Pending 2  Accident investig 3  Suicide 6  Could r 4  Homicide determi	ation	-	_		Yes 2 No	28f. Location (S City or Tov	Street and Num. vn, State)	ber or Rural Route Number,
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To th withir To th comp	Me	29b. Signature and title of certifier	llo	,		29c. License	e number		29d. Date signe	ed (Month, Day, Year)
11.		Janel	Bur	ren	2	D43	5042		11/14	1/2007
1020		30. Name and address of person	al Ka	ad o	Suit	te 205	Pin	ce Fr	eden	ch, MD 206:
St Regist	ate trar	31. Date filed (Month, Day, Year) NNV 16	2007	egistrar's Signati	ure					,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Peggy Ann English November 2007 /Medical Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Dorche 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 KF 217-28-2705 76 Director 1931 Pennsylvania 21, Apr. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1√Yes 2□No Director MD Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "naturai", or items 23a or other traumatic event, the Medical Examiner must be 201 Mapleton Street 21643 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Yes 2√ No White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sports Wear Seamstress (Grad.) Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental ပ္ Sanford Franklin English Maggie Hughes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Mapleton St., Hurlock, Carol English/ Sister MD 21643 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Unity-Washington Cem. 11/16/07 Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** rebrovascular luknown disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ears Sequentially list conditions, if any, sealing to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No for Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performed? certificate Physiclan: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onli on-Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11-12-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grady 8221 Teal 204 tasto 31. Date filed (Month, Day, Year)

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State Registrar DHMH 17 Rev 1/2001

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**ORIGINAL** 

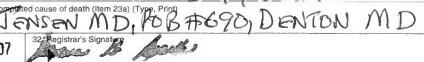
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per dr., g875,01/24/08dhb verb.

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Percy Palmer Eaton Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline 12665 Hog Lot Road Ridgely If Under 24 Hrs. Hours Min. 8. Date of Birth Dec 23 1935 7. Age (In yrs. last birthday, 1 Year Days 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2□ F Maryland 71 218-34-7755 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Caroline Ridgely Maryland 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or Items 23a or 12665 Hog Lot Road 21660 U.S.A. Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within if Health and Mental Hygiene, item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Traffic Safety Coordinator road contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Eaton Anna Pinder Eaton ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie S. Baker/ daughter 11467 Reed Circle; Ridgely, MD 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages Department of I Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/6/07 Ridgely Cemetery Ridgely, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Entér the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory affest, Approximate Interval Between Set and Death Immediate Cause (Final CARCINOMA OF Physician YRS' disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that in illuded events resulting in death) Last Lus to (or as a consequence of) Examiner and Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. ☐Yes 2☐No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, γq 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' certificate 1 ☐ Yes 2 ☐ No 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours Itter death. To the Funeral Director: After Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗀 Homicide To the Hospital 29a. Certifier 🖻 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar



RS

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day $p_{M}$ 4:00 2007 November 6, Elliott George Andrew 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 321 University Blvd., West, #127 Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **1** M 2 □ F Days Hours 029-16-1333 81 June 11, 1926 Massachusetts Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 321 University Blvd, West, #127 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married SpeciWhite 1 ☐ Yes 2 No Specify. 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Lineman Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Regan Percy A. Elliott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Barbara Young/Daughter 3111 Madison Street, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 12, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) More than 5 Conjestive Heart Failure Due to (or as a consequence of) years Due to (or as a consequence of): Due to (or as a consequence of):

**Physician** /Medical Examiner

Physician

Examiner

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

traumatic event,

should be filed within 72 hours after death v nd Mental Hygiene. marked other than "natural", or items 23s

d 2 should be fii h and Mental H ' Is marked oth

permit. Pages 1 and 2 st Department of Health and Important; If Item 27 Is n any Injury or other traun

Maryland 21215-0036

Baltimore,

/Medical

Director

Funeral

2

Completed

Be

10a. State

10

be executed

Box 68760.

P.O.

Division or Vital Records.

Examine burial-transit physician the burial Physician/Medical as led by the attending I signed to 2 Completed funeral director, Be

been

has

certificate

Certification: To Medical

e Hospital or Attending Ph 24 hours after death. e Funeral Director; After th filled in by the 24 To the I within 2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last IF FEMALE 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes XXNo 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be 3 ☐ Suicide 4 Homicide

29a, Certifier

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

9 Unknown

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Day Year 23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed? Yes 2 No 1☐ Yes

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of

29c. License number D32417

29d. Date signed (Month, Day, Year) November 7, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rahul Gilotra, MD 12016 Georgia Avenue, Wheaton, MD 20902

31. Date filed (Month, Day, Year)

NOV 08



State

Registrar

State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) November 10, 2007 **Physician** Feehly 5:47 a M J. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Charlotte Hall Charlotte Hall Veterans Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Hours 1**∄**M 2□ F 217-01-6129 89 Jan. 18,1918 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director St. Mary's Charlotte Hall Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23s or 29449 Charlotte Hall Road 20622 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 XX Yes 2 □ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 10 Printer State of Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth ery lajury or other traumatic event QDCS. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel J. Feehly Anna M. Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9716 Driftwood Lane, Hagerstown, MD Pat Gordon/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State t

Burial 2 □ Cremation 3 □ Removal from State Meadow Ridge Ceme. 11/13/2007 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lic Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 ₩ M00817 23a. Part 1. Enter the disease, or complications that caused the reath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sa ventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Exam nding physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal de 23d. Date of delivery 23b. Was decedent pregnant sete has been signed by the atter page 2 should be detached for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? performed? this certificete 2 No 1 Tes 2 No 1 Tyes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0057574 11-12-2007

State Registrar 31. Date filed (Month, Day, Year)

NOV 1. 4 2007

32. Registrar's Signature

30. Name an address of person

Charlotte Hall, MD 20622

ause of de th (Item 23a) (Type, Print)

			For State Registrar	State	of Mar	yland / Dep <i>Ce</i>	artment ertificate			and M		gien Reg. N	e 200	7	37696
Н			1. Decedent's Name (First, Middle,	Last)			-		-		2. Date of De Month			Ke'ar	3. Time of Death
•	Physicia /Medic		Joan Marie	Ford							November			007	3:00 a M
	Examin		4a. Facility Name (If not institution, g	give street and n	umber)		4b. City,	Town, or	Location of	of Death		4	c. County o	f Death	
24		111	Himalayan Elder						er Spr	-				gome	
eis 1	Funeral Director		5. Social Security Number 6 577-42-9441	.Sex 1	7. Age (	(In yrs. last birthda) 76 Yrs.	Months	1 Year Days	If Under: Hours	Min.	8. Date of Bird (Month, Da July 6,	y, Yea	)	Coui	place (State or Foreign htry) Lct of Columbi
Н			Usual Residence of Decedent								001) 0,				
	yland		10a. State 10b. County		1	I0c. City, Town or L	ocation							1	Od. Inside City Limits
	a-f sl	ctor	Maryland Montgom	ery			Si	ilver	Sprin	g					1 □Yes 2 ☑ No
	or 28	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of WI	hat Cour	ntry?
	23a ust b		2921 Leisure Wo						2090					J.S.A	
	tems er m	Funeral	11. Marital Status	12. Was De Armed F			Was Deced	ent of Hi ify Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	-		<ul> <li>Americ</li> <li>White,</li> </ul>	ean Indian, etc.
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", are items 23a or 28a-f show are marke event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, 0 Year or	i 2 █ No Give Datos:		1 ☐ Yes 2	2⊠ No	Specify:				Specify:		White
8	hour Itural	ed b	15. Decedent's		Dates.	16a. Dec	edent's Usua	d Occupa	ation			16b.	Kind of Bus	iness/In	dustry
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פ	e filed wi al Hygien other th vent, the	Be C	17. Father's Name (First, Middle, La	ist)					18. Mothe	r's Name	e (First, Middle,	Maide	n Surname	)	
<u>a</u>	Ment Ment arked	10	William Flahe	rty						Anna	T. Stor	nont			
Maryland 21215-0036	12 should be filed w h and Mental Hygie is marked other t raumatic event, th		19a. Informant's Name/Relationship	, ,,		1	-				al Route Numb			. ,	Code)
2	and tealth m 27 her to		Carol A. Nelson -	Daughter	•						ney, Mar			_	
0	it of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		m State	20b. Place of Disp cemetery, cr			1				Location - C	•	
altimore,	it. Pa		4 □ Donation 5 □ Other (Spe			Gate of H	eaven C 22. Name an		-		3/2007	Sil	ver Sp	ring,	, Maryland
Ва	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Fundal Service Li	Sensee .	رث	] ]	Hines-Ri	inald	i Fune	ral H	lome, Inc nue, Sil	ver	Spring,	, Mar	yland 20904
۳			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that	t caused the	ne death. Do not e	nter the mode	e of dyin	g, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to	o (or as a	consequence of):									
B	_xammor	7	Sequentially list conditions,	b. Due to	n (nr as a i	consequence of):									
	rted nsit	nine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	oondequence on.											
<u>,</u>	execun and ial-tra	Examiner	that initiated events resulting in death) Last	c Due te	o (or as a	consequence of):									
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9	rtifical g ph as th	/ledi	IE EENALE.												
Box	death certific attending p	an/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o			□Ectopic pr	egnancy					23d. Date		*
о. П	ie dea the at ned fo	Physician/Me	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4□Pre- 9□Unk		me of death 5	Other (sp	ecify)					Mon	uı	Day Year
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æ	he lav e has ige 2 :	mp									auto perfo	psy ormed?	pr de	rior to co eath?	mpletion of cause of
Vita			25. Was case referred to medical						26 Place	of Deat	1 Yes h (Check only o	2KIN	lo 1	∐Yes	2 □ No
>	Physiclan: The Is this certificate had ral director, page 2	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	] Inpatient	t 2 ER/Outpatie	ent 3□ DO	Othe	DF:		me 5□Resi		6 ∏Othe	r (Sneci	fv)
0	Attending Physiclan: r death. ector: After this certifics by the funeral director, I		27. Manner of Death	28a. Dat	te of Injury	28b. Time	of 2	8c. Injury Work			28d. Describe				
0	tendin eath. tor: Af the fur	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	onun, Day	, , , , , , , , , , , , , , , , , , , ,	М		Yes 2□	No					
Division or	or Attendafter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Fla	ce of injury Iding, etc.	y - At home, farm, s (Specify)	treet, factory	, office			28f. Location ( City or To	Street a wn, Sta	and Numbe ite)	r or Run	al Route Number,
	pptal ours a leral C		29a, Certifier 1 Certifying	Physician: To t	he hest of	my knowledge, dea	ath occurred	at the tin	ne. date ar	nd place.	and due to the	cause	(s) and mar	ner as s	stated
	To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by	Medical		caminer: On the		examination and/or									
	To the within To the company of the the the the the the the the the the	ž	29b. Signature and title of certifier	7			290	. License	e number			29d. C	ate signed	(Month,	Day, Year)
	12		/ punc		M	<i>v</i>		D	21340				Novembe	er 8,	2007
			30. Name and address of person w												
	-0-	4.0	Raymond A. Bass 31. Date filed (Month, Day, Year)			errara Driv	e, Wheat	ton,	Maryla	nd 20	902				
	Sta Registr		NOV 0 9	2007	More	w H	Sports	9							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 3 30 per doc 8 per fth 9874 12-4-07 vt state of Maryland? Department of Health and Mental Hygiene 2 0 7 Certificate of Death Reg. No 2. Date of Death 3. Time of Death 6:15 A M 1. Decedent's Name (First, Middle, Last) November 7, 2007 В. F1ax 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Min. 1□M **X**□F Months Hours 93 March 3, 1914 Frederick, MD 578-10-4489 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1X Yes 2 □ No Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8619 Hempstead Avenue 20817 United States Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Education Cafeteria Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Sussel Abraham Brill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13009 North Commons Way Potomac MD 20854 Joel Flax - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grdns 11/9/07 Falls Church, VA 22. Name and Address of Facility
Danzansky-Goldberg, Memorial Chapels Inc
II/O Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Parkinsonism 3 m Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes X□ No 24a. Was an autopsy performe 1□ Yes 2X No 25. Was case referred to medical examiner?

1 ☐ Yes 2 ▼ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner LAX, ANN 1107/2007 9:09am Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran this certificate has al director, page 2 a ours after death.

eral Director: After this certifica filled in by the funeral director, I Hospital or Attending To the Hospital within 24 hours a To the Funeral C completely filled in

Examine

**Physician** 

/Medical

Examiner

MD

Director

Funeral

Completed by

Be

၉

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Š Be Completed Medical Certification: To

Physician/Medical

27. Manner of Death

29a. Certifier

(Check only one)

31. Date filed (Month Day)

1 Natural 2 Accident 5 Pending investigation 3 Suicide 4 Homicide

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1KI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number D37891

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) November 7, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Amit Rajvanshi, MD 121 Congressional Lane #409 Rockville MD 20852

State Registrar

2007





State of Maryland / Department of Health and Mental Hygien 2007

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Marion Montgomery Flook 10727/2007 10:45A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 208 Heron Pt. Chestertown Kent If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 1/16/1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

MA **Funeral** 1 M 2 F Days Hours Min 140-22-0996 83 MA Yrs. Director Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: if item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumetic event, the Medical Experience must be modified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYPY 2 □ No MD Director Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 Heron Pt. 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Spencer B. Montgomery Eleanor Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Flook III/Son 1165 Bacon Ridge Rd. Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation 11/2/2007 \* 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein&Newnam Kils 130 Speer Rd. Chestertown,MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) sician a burial-l Box 68760. Completed by Physician/Medical attending pt IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Fresidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. and title of cartifier 29d. Date signed (Month, Day, Year) 29b. Signarure 29c, License number 100660301 cause of death (Item 23a) (Type Print)

LID STEN RD STE'S CONSTEMTOWN: NWD dlube 10 31. Date filed (Month strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMPLD TIPW/13 per INF. 08/5.1/31/08 WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOV. 3, 2007 Physician 2219 Ashley Maria Figueroa /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | 2 Min. | 1 Month 0 39 / 2 0 0 7 5. Social Security Number 9. Birthplace (State or Foreign Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F none Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Madical Examiner must be notified at Silver Spring MDMontgomery 1 Yes Z No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 20902 USA 2011 Georgian Wood Place iteme 23a deeth Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be tiled within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or item eny injury or other treumatic event, the Midigal Executa 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Guatemalan Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) none none 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Amparito B.Garza Alvaro Figueroa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co209922011 Georgian Wood Place Silver Spring, Md Alvaro Figueroa/Father 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gate of Heaven 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 11/06/2007 Silver Spring, Md 4 □ Donation 5 □ Other (Specify) 21. Signatur Funeral Service PHILIP ACCE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Anecephalic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): inding physicien and use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) sete has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificete 2**X** No 1 ☐ Yes 2 ☐ No 1 Yes After this certification funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death To the Funeral Director: completely filled in by the 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Smyothe MI Nov 2007

State Registrar 1500 Forest Glen Rd. Silver Spring, Md 20910

30. Name and address of person who completed cause of death ("er" 23a) (Type, Print)

MD

32. Registrar's Signature

G. Smigocki onth, Day, Year) NOV 0 8 2007

31. Date filed (Month,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For	State of Maryland				lental Hy	giene		
			= State Registrar		Cer	tificate of L	Death		Reg. No.2	007	37700
۳	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Magaret			Find	cane	November		2007	- 06:30 AM
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БН	-5		30. Name and addre	ess of person to o	completed caus	e of death	(Item 23a) (T	ype, Prin	110 1	v di	.1	(10.		10	h m
	Sta Registra		31. Date filed (Monta	h, Day, Year)	32. 7	pgistrar's	Signature	Span	Add the state of t	( ) ( )		com	<i>U</i> )	10 6 3 60.	John M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:30P M use IYEEW 03 Ü 07 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hyattsville P. G. County Sacred Home Heart If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 ₩ F 94 07-09-1913 Director 579-20-0485 Wash., D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MD Prince Georges Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 USA 903 Applewood Street Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black ģ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Clerk Federal Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Wedge Emma Lee ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Applewood Street Capitol Heights, MD (God-Daughter)

| Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Capture | Cap <u>Alfreda Harris</u> 20743 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 11-09-2007 01ivet Washington, D.C. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ralph Williams Funeral Service 1813 Potomac Ave., SE; Wash., DC Ralph Williams Funeral 1813 Potomac Ave., SE; W

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20003 Approximate Interval Between Onset and Death Immediate Cause (Final 2 days Physician disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ mellitus 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy nerform certificate Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ို 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) To the Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Director: oletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 043121 Chowdly, mo

State Registrar

31. Date filed (Month, Day, Year) NOV 0 8 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** William Carroll Gatton 2007 5:20 p.m. November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Nursing Center <u>Leonardtown</u> St. Mary's Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1XM 2□F Director 220-34-3391 97 10/27/1910 Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 TYes 2X No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Exa⊞iner must be 23896 Point Lookout Road 20650 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene. is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: White Specify. 2 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5 Jailer-Bailiff State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ William Robert Gatton Ada Banagan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 Health em 27 i Department of Health Important: If Item 27 any Injury or other tr Charles B. Gatton / Son P.O. Box 269, Callaway, Maryland 20620 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Our Lady's Cemetery 11-16-2007 Leonardtown, Maryland 21. Signature of Funeral Service Livensee
Edward N. Brinsfield, Jr. M00052 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bleed Physician I /Medical Due to (or as a consequence of): **Examiner** Atmial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sentennion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

M.D.

29c. License number D40888

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakhi Krishnan, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636

31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

			For State Registrar	State of Maryland		artment of H r <i>tificate of L</i>			jiene <sub>leg. No</sub> 2 () (	17	37704			
1			Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of Death			
	Physicia /Medic		Floyd E. Gurley	Jr.				Month Novembe		Year 107	1:40 P <sup>M</sup>			
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	1	4c. County of	f Death				
			Calvert Manor He			Risin		T. D. (5:0	Cec					
Ţ	Funeral			M OFF	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Coun				
	Director		347-10-9937 Usual Residence of Decedent	88				April 14	, 1919	MIS	souri			
	yland now at		10a. State 10b. County	10c. City	, Town or Lo	cation				16	Od. Inside City Limits			
	a-f st	ctor	Maryland Cecil	Co	nowing	30					1 ☐ Yes 2 <b>X</b> No			
	or 28	Dire	10e. Street and Number			10f. Zip Code		1	10g. Citizen of W	hat Coun	try?			
	ath w	la	1670 Liberty Gro			21918		76.37	USA	Americ	an Indian			
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examilier must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.9 Armed Forces? 1 X Yes 2 □ No if Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🎇 No	spanic Ongin? (Sin, Mexican, Puert	pecity Yes of No- o Rican, etc.)	14. Race Black Specify:	White,	etc.			
21215-0036	'2 hou	Completed	15. Decedent's Edu (Specify only highest grad	cation		dent's Usual Occupa		kina	16b. Kind of Bus	siness/Inc	lustry			
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21	ed wi ygien her th t, the		8		Forer	nan	10 Mathada Nan	na (First Middle			Poultry			
Maryland	be fill ntal H ed oth even	B	17. Father's Name (First, Middle, Last)					ne (First, Middle,		"				
1	should be and Mental marked o	٩	Floyd E. Gurley  19a. Informant's Name/Relationship (Ty	rno Print)	10h Maili	ng Address (Street a		ce Fishe:	<del>.</del>	State Zin	Code)			
Ma	d 2 sho th and 7 Is ma trauma		Barry Montgomery		1	6. Queen S					,			
	Health Health tem 27		20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of	i	Date	20c. Location - 0					
Baltimore,	permit. Pages 1 and 1 Department of Health Important: If item 27 any injury or other tr once.		1 ☐ Burial 2 【Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State		matory or other place oard Fune:	, <u> </u>	1-13-200	7 Rising	Sun.	Maryland			
<b>=</b>	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens		2:	2. Name and Addres	ss of Facility			,	<b>-</b>			
ä	permi Depar Impor any ir once.		Okushard L.	Gradie	11	. T. Foard 11 S. Que	n Funera en Stree	t ноme, t, Risin	g Sun, M	ID 21	911			
			23a. Part I. Enter the disease, or compl shock, or heart failure. List only of	ications that caused the death	. Do not en	ter the mode of dyin	g, such as cardia	or respiratory ar	rest,		Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	disease or condition requiring a 17 cm ( C) need ve Hourt Junie 2 weeks										
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	7	11	7	0					
ь	Examiner	Ļ	Sequentially list conditions,	- 13che	mic	-Can	diom	Johat	hy		5 years o			
RT	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	erice or).	Arto	2 1	Dies	_		25 50			
	ficate be executed physician and s the burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a consequ	uence of)	1110	nal	pre	76		x 5 years			
68760,	e be e	edical E		d										
Вох	law requires that the death certific as been signed by the attending pl 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		□Ectopic pregnancy	,		23d. Date Mor		ery Day Year			
	the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	eath 5[	Other (specify)			l moi	III I	Day Tour			
P.0	hat th d by t	Ph.	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the L	inderlying cause give	en in Part I.	23e. Did to	bacco use contri	ibute to th	ne cause of death?			
Records,	w requires that the de been signed by the should be detached	i by	Dolahette	- Melle	4+1	J. T		101	res 2 □ No	3 ☐ Prot	pably 4 Miknown			
Ö	v requ been shoul	Completed	900 00	( ) ( ) ( )	1	10160	-	24a. Was	an 24h V	Vere auto	nev findings available			
Rec	The lav	dm	Jenjonesn	Vancon	~	ansec	_	autop	rmed?	eath?	psy findings available mpletion of cause of			
	in: T ificate or, pa		25. Was case referred to medical				26 Place of Dec	1  Yes ath (Check only o	-	□Yes	2□No			
or Vital	Physician: r this certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Oth		lome 5□ Resid		er (Specit	iv)			
٥	g Phy ter thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injur World		T .	now injury occurre					
ior	Attending r death. ector: After you the fune	atio	1 Datural 5 Pending 2 Accident investigation	(//////////////////////////////////////	,,		Yes 2 □ No							
Division	or Atter de Directe in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specif	me, farm, st v)	reet, factory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	er or Rura	al Route Number,			
	oital ours af aral D					4b d -4 4b - 4'-			/-)		*-*- d			
	the Hospital hin 24 hours a the Funeral upletely filled	Medical		sician: To the best of my kno Iner: On the basis of examina and manner stated.										
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Mec	29b. Signature and title of certifier	2 0 ( 0 -		29c. Licens	e number		29d. Date signed	(Month,	Day, Year)			
	FSFÖ		E Supertil	ml-16 fals	· MI)	20	0223	07	NOVI	12,	2007			
			30. Name and address of person who c	ompleted cause of death (Item	1 23a) (Type	, Print)								
2	EXIVA		JAYANTILALI	K. PATELMI)	138	Cathea	eral 8	7- Elk	ton	mI	21921			
	Sta		31. Date filed (Month, Day, Year) NOV 1 3 2	32. Registrar's Signa	ture	backs			/					
	Regist	rair	132	COLLEGE .	10.									

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

Drooks 32. Registrar's Sign 29c. License number

29d. Date signed (Month, Day, Year) November 6, 2007

29d. Date signed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore, Maryland 21215-0036

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

**Funeral** 

Director

**Physician** /Medical Examiner

burial-tran ţ, attending p signed by the a To the Hospital or Attending Physician: this within 24 hours after death.

To the Funeral Director: Af

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

by	3 AWidowed 4 ☐ Divorced	Year or Dates:	1 Li Yes 2Ł⊠ No	Specify:		Specify: B1	ack					
To Be Completed by	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working	16b. I	Kind of Business/	Industry					
dm	Elementary/Secondary (0-12)	College (1-4or 5+)	Restaurant Wo	_	I .	od Servi	3.0					
ပ္ပ	17. Father's Name (First, Middle, Last)		Restaurant wo		(First, Middle, Maide							
) Be	William Cob			Susie Ba								
F	19a. Informant's Name/Relationship (T	ype <sub>4</sub> Brigt)	19b. Mailing Address (Stree	t and Number or Rura	I Route Number, City	or Town, State, 2	Zip Code)					
	Rosemary Mason/Per		Prince George 6420 Allenton	es County yn Road C	Area Ageno amp Spring	y on Agi	ing 20748					
	20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐	20b.	Place of Disposition (Name of cemetery, crematory or other place)	nce)		Location - City or						
	4 □ Donation 5 □ Other (Specify		surrection Ceme			nton, MI						
	21. Signature of Funeral Service Licens	(14. *	22, Name and Addr 246 N. Was		-		Funeral Švo					
	23a, Part1, Ever the disease, or comp					VIIIe,	Approximate					
	shock, or heart failure. List only of	one cause on each line.	ath. Do not enter the mode of dy	ing, such as cardiac o	ir respiratory arrest,		Interval Between Onset and Death					
	disease or condition resulting in death)	u.	1 Infarction				15 mins.					
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min	i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Cerebrova	scular Accident				years					
Exa	resulting in death) Last	Due to (or as a conse	equence of):				•					
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ian/	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe	etal death 3 Ectopic pregnan	су		23d. Date of de Month	Day Year					
ysic	1 ☐ Yes 2 12 No 9 ☐ Unknown	9 Unknown	Tuedin 3 other (specify)	···	*							
y Pr	Part II. Other significant conditions of	ontributing to death but not re	esulting in the underlying cause g	iven in Part I.	23e. Did tobacco	use contribute to	the cause of death?					
q pe	_Arthritis			<del></del>	1 ☐ Yes	2⊠ No 3□ P	robably 4 Unknown					
plet					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of					
mo:					performed? 1□ Yes 2⊠	death?	2 □ No					
Be (	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)							
2	1 ☐ Yes 2 🔀 No		DENOutpatient 3D DOA		me 5 Residence		ecify)					
ation:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		ury at ork? □Yes 2□No	28d. Describe how in	jury occurred						
ertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, street, factory, officiality)		28f. Location (Street City or Town, Sta	and Number or R ate)	ural Route Number,					
dical Certification: To Be Completed by Physician/Medical Examiner			knowledge, death occurred at the ination and/or investigation, in my									

State

Registrar

29b. Signature and title of certifier

Raman R. Tuli, 31. Date filed (Month, Day, Year)

NOV 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29c. License number

10810 Darnestown Road Suite 202 Gaithersburg, MD

19609

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 005 2007 er 2n November G /Medical acility Name (If not institution, give 4b. City 4c. County of Death Town, or Location of Death Examiner en If Under 1 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs **Funeral** Months Hours Days 1 □ M 2 😾 F 89 Director 214-52-0124 Oct. 13, 1918 MD Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Queen Anne's Church Hill Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1030 Sudlersville Rd. 21623 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical Elementary/Secondary (0-12) College (1-4or 5+) the 12 Homemaker Own\_Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be John W.Holden Clara Faulkner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If Item 27 is any injury or other trau Gladys Griffin/Daughter 1031 Sudlersville Rd. Church Hill, MD 21623 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/6/07 Church Hill Cem. Church Hill, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Fellows, Helfenbein&Newnam 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WRE neumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending physical for use as the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes Division or Vital Records, P.O. the detached 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy perform Yes 2 □ No Physician: director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral or 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 30 Name and addres of person who completed cause of d th (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

MS

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 720M udwig 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Center River Kent hester md Date of Birth (Month, Day, Year) 9/5/1915 5. Social Security Number . Age (In yrs. last birthday, **Funeral**  Birthplace (State or Foreign Country) 1 M 2 → F Months Days Min. 209-36-8172 92 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f show must be notified at 1X Yes 2 □ No Director MD Kent Chestertown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 216 Birch Run Rd. 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian. 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify 2 3 Widowed 4 □ Divorced "natural", Year or Dates Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Ludwig Edna Lewis ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other tr once, 27 Richard Goodall/Son 1 Byford Ct. Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fellows, St. Paul's Cemetery Chestertown, MD Hellenbein Newnam 21. Signature of Funeral Service Licenses 130 Speer Rd. Chestertown, MD 21620 Kuk 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician VA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, breade or highly that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending ph 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown AKKYTHMIA 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ADVANCED ACIG 24a. Was an certificate has b irector, page 2 s autopsy performed? Yes 2 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 phopatient Medical Certification: To 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

12 m

31. Date filed (Month, Day, Year)

OCT 3 0 2007

30. Name and

1 2007 32. Resitrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month John William Griffin November 6, 2007 2:57 р 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1**⊠**M 2□F 92 577-16-5116 June 17, 1915 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12409 Galway 20904 Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 ☐ No Specify: SpecifyWhite 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Lawyer 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Will Oles Griffin Edna Faye Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. Griffin/Wife 12409 Galway Drive, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State November 10 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Burtonsville Union 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 2007 Purtonsville, Maryland 21. Signature Fur eral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Apsiration Pneumonia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown

**Physician** /Medical **Examiner** 

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page 2

the funeral director

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physician

Department of Importent: If any injury or once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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Funeral Director

Completed by

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Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

death with the Maryland

72 hours after

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Pages '

The law requires that the death certificate be executed

Division of Vital Records, P.O.

or Attending Physicien:

after death.

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it of Health

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

1 Tes 2 No 3 Probably 4 Nunknown

Coronary Artery Disease

autopsy performed' 2 X No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 🙀 No

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death **x** Natural ☐ Accident 3 🗌 Suicide

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the vasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D32417

29d. Date signed (Month, Day, Year) November 7, 2007

30. Name and address of person completed cause of death (Item 23a) (Type, Print)

Raul Gilotra, MD

31. Date filed (Month, Day, Year)

12016 Georgia Avenue, Wheaton, MD 20902

State Registrar

NOV 0 8 2007



DHMH 17 Rev 1/2001

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			1 - For State Registrar			ertificate of			2007	37710
	Physici	án	1. Decedent's Name (First, Middle, Last)	)				2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic Examin	al	John Carroll 4a. Facility Name (If not institution, give s	Gilliam street and number)		4b. City, Town, o	or Location of Deat	NOV	7, 2007 4c. County of Dea	0200 M
_ <			Forest Glen Nursi				Spring		Montg	gomery
	Funeral Director		5. Social Security Number 6. Sex	7. Age M 2□F	(In yrs. last birthday	Months Days	Hours Min.	. (Month, Day	(, Year) 9. Bi	rthplace (State or Foreign country)
	ס		215-38-7458 Usual Residence of Decedent		66			JUL 17	, 1941 was	hington, DC
	Aaryla e how	ō	10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 X No
	r 28a-f	Director	Maryland Montgome: 10e. Street and Number	ry	Silver S	Spring 10f. Zip Code		1 .	l 0g. Citizen of What C	
	23£ o		2700 Barker St.			209	10		United Sta	ites
	er dea Items	Funeral		12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
036	urs aft el', or Enemi	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify: Wh	nite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23s or 28s-f ehow ant, I're Medical Examinat must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Dec	edent's Usual Occup e kind of work done	pation during most of wo	rkina	16b. Kind of Business	
121	within ene. than '	lduc	Elementary/Secondary (0-12)	College (1-4or 5+	) life.	DO NOT use retire	d)		Communit	
b D	e filed al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)		Comp	outer Tecl		me (First, Middle,	Comput Maiden Sumame)	ers
ylaı	ould b Ments harked	<b>To E</b>	Carroll Stewart Gi				Clara			
Maryland	d 2 sh th and th end theum treum		19a. Informant's Name/Relationship (Ty) Gina Magrino / Daug	•					r, City or Town, State, FL 32835	
ē,	s 1 an if Heal item other		20a. Method of Disposition	-	20b. Place of Disc	ment of the continue of the co	T	Date	20c. Location - City o	
Baltimore,	Page ment c ent: If		1 ☐ Burial 2 🕅 Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Chesapea Cremator	ke		3/2007	Beltsville	e, Maryland
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Items 23c or 28a-f show emportent: If item 27 is marked other then "naturel; or Items 23c or 28a-f show emy injury or other treumatic event, Item Medical Examination and once.	ĺ	21. Signature of Funeral Service Liganse	'e_	A STATE OF THE STA	<sup>2. Name and Addre hibadeau 33 Gist A</sup>	ss of Facility Mortuary	Service		
			23a. Part 1. Enter the disease, or compli	M00 cations that caused t	he death. Do not en					20910 Approximate
	Prysician	9 9	shock, or heart failure. List only on Immediate Cause (Final disease or condition		er's Disc					Interval Between Onset and Death
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ŏ	death certifica e attending ph of for use as th	Physiclan/Med	230. Was decedent pregnant	3c. If yes, outcome of 1□Live birth 2		□Ectopic pregnancy	,		23d. Date of de	•
.O. Box	he dea the at thed fo	ysicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at ti 9☐Unknown		Other (specify)			Month	Day Year
<u>a</u>	The law requires that the te has been signed by thogge 2 should be detache	by Ph	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
Vital Records,	w require: been sig should b	ted b	Severe Dementia					1 🗆 Y	es 2□No 3□P	robably 4 XUnknown
ecc	e 2 sh	Completed	Alcoholism					24a. Was a autops	v prior to	utopsy findings available completion of cause of
			Peripheral Vascul 25. Was case referred to medical	ar Diseas	e			perform 1 Tes	2XNo 1 ☐ Ye	s 2 <b>∑</b> No
		To Be	evaminer?	ospital:	2 ☐ ER/Outpatie	nt 3 DOA Oth	00	ath <i>(Check only or</i> Home 5 ☐ Reside	ence 6 Other (Spe	acify)
Division of	<u>a</u> ≠ <u>a</u>		27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (	Wor	y at k?		ow injury occurred	,
ISIC	or Attend after death Director: , in by the f	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injun	/ - At home, farm, st		Yes 2 □ No	28f. Location (Si	reet and Number or R	Tural Route Number.
S	s after al Dire	Certi	4  Homicide determined	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	n, State)	
	o the Hospitel or Attending thin 24 hours after death. the Funeral Director: After ampletely filled in by the funer	edical	29a. Certifier 1 X Certifying Phys (Check only one)	ician: To the best of er: On the basis of e and manner state	xamination and/or ir	th occurred at the tin evestigation, in my o	ne, date and place pinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Mon	th. Day, Year)
7	(3)		· Chowdly,	mj		D431	121	1	1/7/2007	
1			30. Name and address of person who cor			,	411. NO	20066		
	Sta	e	Nurul Chowdhury, M 31. Date filed (Month Cay, Yoar) 201	32. F gistrar'	Dino Dr., s Signature	burtonsv	ттте, МД	20866		
	Registra	ar	1404 0 9 201	Ul Berlie	J. J. J.	2802				

State Registrar 31. Date filed (Month, Day, Year) NOV 0 8 2007

Michael Baako

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only

29b. Signature and title of certifier



MITTENDING

PHYSI CIA

3450 Fort Meade Rd #209 Laurel, Md 20724 *∰*egistrar's Signature

29c. License number

D0057216

29d. Date signed (Month, Day, Year)

Nov.5,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0836 2007 Linda Duggins Garfield Nov /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Gounty of Death Examiner SALISBURY MEDICAL CENTER COMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 12, Birthplace (State or Foreign Country)
 PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months Days 1 □ M 2 🔀 F Hours Director 220-84-9497 1963 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No must be notifled Directo Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 23a 116 Washington St. 21804 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc Examiner 1 ☐ Yes 2**X** If Yes, Give Year or Dates: 2**X** No or i 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black Specify. þ Specify: 3 Widowed 4 Divorced "natural" Completed 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Retail Sales Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 Is marked o any Injury or other traumatic eve Donald Ray Jordan Rose Duggins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laneca Duggins/daughter 116 Washington St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Acres Mem Park | 11/10/2007 Salisbury, MD 21. Signature of Functal Service Licensee 22. Name and Address of Facility Lewis N. Watson Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) NELMONIA **Physician** /Medical **Examiner** CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha autopsy performe 2 **N**0 2 [ ] No 1□ Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1/ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖊 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 29b. Signature a

31. Date filed (Month,

nd title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St. Salisbuny Md

29c. License number

29d. Date signed (Month, Day, Year)

12007

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 1700 Bobbie Garland November 10,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Hospital Westminster Carroll 7. Age (In yrs. last birthday) If Under 1 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min. Months Yrs. November6, 1935 North Car. 72 Director 218-80-3650 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 X Yes 2 ☐ No Director Maryland Carroll Sykesville 10g. Citizen of What Country? 10e. Street and Number 4710 Bartholow Road 21784 by Funeral A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "natural", or iten the Medical Examiner Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Z Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles W. Garland Mae Forbes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tammy Lipton/Daughter 4117Littlestown Pike Westminster Maryland
se of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/15/07 Bakersville, N. C. Garland Cemetery : 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P. A michael Melly 6009 Harford Road Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OF CI FRACTURE COMPLICATION **Physician** 50A45 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician the burial Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2☑No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient ို 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 7:47 PM 1 Natural 5 Pending 6/2007 investigation 1 Yes 2 No ATIENT 2 Accident after death 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in 4710 Bartholow Rd. Sykesville 24 hours a 烂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 24 29c. Light 19 20 5 5 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Poole Rd WESTMINSTER MD MAGANNA JWA COURISHANKAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien 9 17 37715 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2007° 3 Nov. Ε. 3:20 Ам Barbara Gawler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Homewood 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕱 F 79 Yrs. 579-30-4483 Director Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28s-f ehow the Medical Examinar must be notified at 1 ☐ Yes 21 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 United States 7407 Willow Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Repair 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth any jury or other treumatic event once. Mary McGurl Charles Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 144 Puma Dr., Hanover, PA, 17331 John Gawler / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Stauffer Crematory 11/7/2007 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home P.A., Brodle 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Michal. **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes Albo
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes ŽENo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes 2100 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be determined Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M > 30. Name and address of person who completed cause of wath (Item 23a) (Type, Print) Frederick, MD 21701 Casper E. Cline 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 8 2007 Registrar

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07-08916								
John I	Groff							

hn L. G	roff	1-	St For State	ate of Maryla	and / Depai <i>Cert</i>	rtment of tificate of	Health and Death	Mental	l Hygiene	Reg. No.	20	107 3771	
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215 e file	Mental Hygiene. marked other than c event, the Medica	Be C	George Willa	ard Groff	Jr.			Je	ean Ire		ilvers_	ato Zin Code)	
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Z Z	Ith an n 27 i		Rhonda Corbet	t- Sister	20h	Place of Dispo	7 Secris- sition (Name of cer	netery.	Date	20c	Location - City	or Town, State	
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Baltimore,	petinit. I ages I amu 23 Department of Health at Important: If item 27 injury or other traum:		21 Signature of Funeral Service	Licensee		142	5 S. Cond	ocochi	eague S	t. Wil	liamspo	rt, MD 21795	
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	aminer	li i	Immediate Cause (Final disease or condition resulting in death)  a. Cirrhosis of liver  Due to (or as a consequence of):										
			Sequentially list conditions,	b					_				
		iner	if any, leading to immediate cause. Enter Underlying Cause		s a consequence	OT):							
	(Disease or injury that initiated Due to (or as a consequence of):												
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)9/	eath certificate b attending physi for use as the bu	sician/Me	IF FEMALE: 23b. Was decedent pregnant in	10 -	s, outcome of pre e birth		etal death 3	Ectopic	pregnancy	- 1	Month	Day Year	
89	eath certi attendin for use as	Cia.	past 12 months?		egnant at time of o		Other (Specify)						
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<u> </u>	certifi ector.	l a	25. Was case referred to med	dical Hospital:	Invaliant 2	✓ EP/Outpatie		Other <sub>4</sub>	Nursing Home		sidence 6	Other:	
examiner?  1 Ves 2 No  28b. Time of Injury  28c. Injury at Work?  28d. Describe in the injury  28d. Describe in the injury  28d. Describe injury									injury occurred				
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D.	tal or rs afte ral Dir	Certification:	3 Suicide 6 6 Homicide	Could not be determined (Spec									
_	20 Configure 3 and due to the cause(s) and manner as stated.								s stated. e to the cause(s)				
	To the 1 within 2 To the 1	Medical	one) 2 Medical	Examiner: On the ba and mann	sis of examination	n and/or investi	gation, in my opini	on, death o	ccurred at the ti	ille, date and	place, and doe	(Month, Day, Year)	
	F ≥ F 8	\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	29b. Signature and title of ce	rtifier	n (			nse number	ı		November 1		
	1	Maybre Me Sould O.C.M.E.							November 10, 2007				
			30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
			Margarita Korell M		2. Registrar's Sign	nature							
		Stat istra	31. Date filed (Month, Day, Y	2 0 2007	harry	5	a del						

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year Davis John Hissey 08,2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner hari2 Mod ica enter 0 8. Date of Birth (Month, Day, Year) Oct. 8, 1942 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1**X** M 2□ F Maryland 216-40-2299 65 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director St. Mary's **Mechanicsville** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39012 Cooney Neck Road 20659 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 21 No Specify. à Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Non Commissioned Officer Dept. of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Hissey **Helen** Isabel1 Barker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38996 Cooney Neck Rd., Mechanicsville, MD 20659 Kevin McConnell/Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Cr. 11/10/2007 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 21. Signature of Funeral Service Lice M00817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Septic Shock Immediate Cause (Final days. disease or condition resulting in death) Due to (or as a consequence of) Liver Cancer Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 **X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death Certification:

certificate be executed attending physician and for use as the burial-tran-Box 68760. P.0. signed by the a d be detached f detached Division or Vital Records, peen has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

**Funeral** 

Director

show r 28a-f show notified at

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r

d 2 should be filed within 7: th and Mental Hygiene. 7 is marked other than "n

permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any injury or other trau

Physician

/Medical

Examiner

Maryland 21215-0036

28a. Date of Injury (Month, Day 5 Pending investigation

28h Time of

28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and fittle of certifier

1 Natural
2 Accident

3 ☐ Suicide

29a, Certifier

Medical

4 ☐ Homicide

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

)an'i vinder

and manner stated.

Suite

State Registrar

iled (Month, Day, Year, NOV 1 4 2007

6 ☐ Could not be

determined



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:30 a.m.<sup>M</sup> November 13, 2007 Brumback Huffman Stephen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's 21514 Warwick Court Lexington Park Year If Under 24 Hrs.
Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days 11X M 2□ F 58 Director 230-62-6700 04/15/1949 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at show 1 ☐ Yes XXNo Director St. Mary's Lexington Park Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 20653 United States 21514 Warwick Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify Specify: White 9 3 ☐ Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Aircraft Fabricator Aircraft 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 90 Elizabeth Grove 2 Winston David Huffman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 21514 Warwick Court, Lexington Park, MD 20653 Dorothy Gass / Daughter other t Department of Healt Important: If item 2' any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Pages 1 ment of h 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other\_(Specify) Brinsfield-Echols Cr. 11-15-2007 Charlotte Hall, MD 4 ☐ Donation 2... 21. Signature of Funeral Strice is ease 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650-0279 Danielle Ward M01403 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Kena Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Causer burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ COA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2, To the I

State Registrar

onne 31. Date filed (Month, Day, Year)

1 6 2007

29b. Signature and title of certifier



WD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

House

24035

29c. License number

29d. Date signed (Month, Day, Year)

hae North Rd Hallyword Md 206366

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) TCKS 442 **Physician** MILDREN 06 Z007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 8. Date of Birth (Month, Day, Year SEPT 24, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Year) Hours Min. 1 □ M 2X F BUTLER, GA 1924 153-22-5320 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State la or 28a-f show t be notified at 1 X Yes 2 □ No Director PRINCE GEORGE'S CAPITOL HEIGHTS MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with 6310 CARRINGTON CT 20743 UNITED STATES Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or item edical Exaπiner r 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: BLACK 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Medical Elementary/Secondary (0-12) College (1-4or 5+) the ! 12th DOMESTIC DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 Is marked othe any lightly or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be LEE JOHNSON VERA JOHNSON ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GEORGE\_L. HICKS SR./HUSBAND 6310 CARRINGTON CT. CAPITOL HEIGHTS MD. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEM. PARK CEM 11/16/07 LANDOVER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lice 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE.. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSC LEROTIC HEART **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner the death certificate be executed Due to (or as a consequence of): g physician a Box 68760. Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? 4□Pregnant at time of death
9□Unknown Month 5 Other (specify) ☐Yes 2 No ed by the a o 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown RENAL Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 ☐ Yes or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred I Director: After to d in by the funera Certification: (Month, Day Year) or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Qay, Year) 29b. Signature and title of certifier 2 By DO0557/8 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WASHINGTON ADVENTIST HOSPITAL, TAKOMAPARK, MD SWITKES, MD

State Registrar NOV 0 9 2007

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

JOSE E V 07-08597	ler	Please Typ	oe or Print in							jible.	
UNK UNK		1- For State	ate of Maryla		artment o ertificate o			ntal Hy		a No. 20	07 3772
Physicia	ın/	Registrar 1. Decedent's Name (First, Midd	le,Last)		7				2. Date of Deat	h	3. Time of Death
Medical Exami		Jose E.  4a. Facility Name (if not institution	Hernandez	mbos)		4h City	Town, or Location	of Dooth	Month November	5, 2007	0710 hrs
1		95 N @ Exit 80	on, give street and nor	niber)		Rive		TOI Death		Harford	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Und		der 24Hrs.	8. Date of Birt	Fore	rthplace (State or
Director		None	1 XM 2 F	27	Yr		is Days Flou	IS IVIII.	Nov.	15, 1979 <sup>c</sup>	<sup>ountry</sup> Guatemala
any	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loca	tion					10d. Inside City Limits
and Show	ō	VA			Arlingt	on					1 X Yes 2 No
r 28a-	Director	10e. Street and Number		· -		10f. Zij	p Code		10	ng. Citizen of What Co	untry?
vith the s 23a o		4317 4th Stre		edent Ever in U	J.S. 13. W	as Deced	22203 ent of Hispanic Or	riain? (Sp	ecify Yes or No-	Guatema 14. Race - Ame	ala rican Indian, Black,
death v or item	uneral	1 Never Married 2 X M	Armed Fo	rces?	lf `	Yes, spec	ify Cuban, Mexica	n, Puerto I	Ricán, etc.)	White, etc.	
s after iral", c	by F	3 Widowed 4 Div	/orced If Yes, Give Year or Dates:				No specific			Specify: Hi	spanic
72 hour	eted	Elementary/Secondary (0-12)					orking life. DO NO			Tob. Killa of business	anidusti y
0036 vithin ene. er tha	Completed	6th			Cons	truc				Self Er	nployed
115-( if filed very set of the	Be Co	17. Father's Name (First, Middle Emilio Hernan		) C					(First, Middle, N na Toj S	Maiden Surname)	
212 ould be d Ment s mark	To E	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Addres	s (Street and No	imber or R		ber, City or Town, Stat	te, Zip Code)
MD nd 2 sh alth an m 27 i		Jose Mario Or  20a. Method of Disposition	tiz - Neph		Anna	dale	sworth C , VA. 22	<u>  003"                                  </u>	Date	20c. Location - City of	or Tourn State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation		om State	crematory or o	ther place	e)	,,		·	C.,
altim nit. Pa artmen oortand iry or o	-	4 Donation 5 Other S 21. Signature of Funeral Service		1 66	eneral (		d Address of Facil Y Funera			7 Baja Ver	apaz,
Per Degraphic		Phillip 1	Bells		4	804	Georgia	Ave.	N.W. V	Vashington.	
Physician M_dical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.		h. Do not enter	the mode	of dying, such as	cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
<b>xaminer</b>		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a		of):						_
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	consequence	of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	e								
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oe exec	dica	UNPENDED	AMENDED								
Box 68760, death certificate be execut the attending physician and ed for use as the burial - trai	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in t		outcome of pre		etal death	3 Ector	pic pregna	ncv	23d. Date of delive	pry Day Year
ox 6 ath cert attendir	sicia	past 12 months?	4 Pregna	ant at time of d	looth	ther (Spe					
D.O. BO; that the deat ned by the att detached for	Phy	Part II. Other significant condit	a Olikilo		resulting in the	underlyin	g cause given in I	Part I.	23e. Did to	bbacco use contribute t	o the cause of death?
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Recc The lav Icate har	Som								1 🗸 Yes	rmed? death?	
/ital sician;	Be	25. Was case referred to medica examiner?	I tennital:	npatient 2	ER/Outpatier	nt 3	26.Place of Deat			Residence 6 ✓ Oth	er: Scene
of Vital Recoing Physician: The law After this certificate has uneral director, page 2.5	<u>ان</u>	1 Yes 2 No 27. Manner of Death	28a Date	of Injury	28b. Time of		28c. Injury at Wo	ork?	28d. Describe I	now injury occurred	
sion ettendi death. ctor: / y the ft	atio	1 Natural 5 Pend 2 ✓ Accident Inve	stigation		0702 hrs		1 Yes 2	V, No			
Division of Vital Records, tat or Attending Physician: The law requirers after death.  "In Director: After this certificate has been silled in by the funeral director, page 2 should be	Certification:	dete	ld not be	e of Injury - At I Interstate		eet, factor	y, office building,	etc.		Street and Number or F state) 50, Riverside, MD	Rural Route Number, City
Hospi 24 hou Funer rtely fil	ia C	29a. Certifier (Check only 1 Certifying P	hysician: To the bes	t of my knowle	dge, death occi			place, and	due to the caus	e(s) and manner as sta	
To the Hos within 24 h To the Fur completely	Medical	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	and manner st		and/or investig		ny opinion, death o		t the time, date	and place, and due to	
	2	29b. Signature and title of certific	Post	$\cap$			O.C.M.E.	51		29d. Date signed (M November 5, 20	
100		30. Name and address of person	who completed caus	e of death (Ite	m 23a)						

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

ORIGINAL

State Registrar

31. Date filed (Month, Day, Year)

Laron Locke MD.

**Physician** /Medical Examiner

**Funeral** 

Director

r 28a-f show notified at show

or e

items 23a ner must b

'natural", or

than the M

27 is marked of traumatic ever

the Maryland

Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and s the burial-tran signed by page ithin 24 hours after death.

the Funeral Director: A propletely filled in by the fu

Division or Vital Records, P.O. Box 68760,

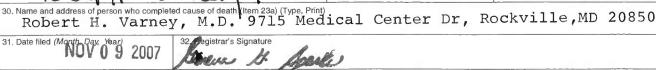
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	c Failure				
dical		<b>d</b>					
Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day	/ Year
ρ	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.		use contribute to the c	
Completed					24a. Was an autopsy performed? 1  Yes 2	death?	findings available etion of cause of No
Be (	25. Was case referred to medical			26. Place of De	ath (Check only one)		
0	examiner? 1 ☐ Yes 2X No	Hospital: 1₺ Inpatient 2	]ER/Outpatient 3□ [	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)	
ation:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) on	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	rry occurred	
Certification: T	3 Suicide 6 Could not 4 Homicide determine		nome, farm, street, factority)	ory, office	28f. Location (Street a City or Town, State	nd Number or Rural Ro e)	oute Number,
Medical (	29a. Certifier 1X Certifying F (Check only one) 2 Medical Ex-	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and plac on, in my opinion, death oc	ce, and due to the cause(scurred at the time, date an	s) and manner as state nd place, and due to the	d. e cause(s)
ž	29b. Signature and title of certifier		2	9c. License number	29d. Da	ate signed (Month, Day	, Year)

11/5/07

State Registrar

29b. Signature

31. Date filed (Month Day, Year) 2007



within 24 To the

2

D20332

			for State Registrar	Otate of Mary	(dild)	Certificate o	f Death		Reg. No.		
	Physici	an	Decedent's Name (First, Middle, Last	_				2. Date of De Month	er 7, 20	Year	3. Time of Death
	/Medic			Hauck		4h Cih Tour	, or Location of Death		er /, 20		9:20 A. M
	Examir	ner	4a. Facility Name (If not institution, give Angels Garden Ass		נ	Rockv				gome	
	Funeral Director		5. Social Security Number 6. S		yrs. last birth		ar If Under 24 Hrs.	8. Date of Bir (Month, Da June 6	av. Year)	Cou	nplace (State or Foreign intry) Jersey
	pu k		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town	or Location		-			10d. Inside City Limits
	Aaryla f sho	5	Maryland Montgome		Rockvi						1 XYes 2 ☐ No
	with the Page or 28s-	Direct	10e. Street and Number 4101 Bel Pre Road			10f. Zip Code	853		10g. Citizen of V		•
30	be filed within 72 hours after daath with the Maryland tal Hyglene. d other than "natural", or Items 23a or 28s-f show avant, the Medicial Examinar must be putified at	by Funeral Director	11, Marital Status  1 Never Married 25 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U.S.	13. Was Decedent of If Yes, specify C	f Hispanic Origin? (Suban, Mexican, Puert lo Specify:	pecify Yes or No o Rican, etc.)	Bla	ce - Amer ck, White y.Whit	
212-0030	72 hou		15. Decedent's Ed (Specify only highest gra	ducation	16a. I	Decedent's Usual Oct	cupation ne during most of wor	rkina	16b. Kind of B	usiness/l	ndustry
Ž	within 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of work do life. DO NOT use ret gistered N		······· <b>3</b>	Hospit	al	
ylana z	m - 0 =	0	17. Father's Name (First, Middle, Last) John Rogalinski					me (First, Middle etrowski	, Maiden Surnar	ne)	
Maryi	d 2 should be ith and Mental it if is marked of traumatic ava	12	19a. Informant's Name/Relationship ( Monica Lavery/Dau	*		Mailing Address (Stre					ip Code)
Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important; if Item 27 is marked any injury or other traumatic as once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4X☐ Donation 5 ☐ Other (Specify	Removal from State	20h Place of	Disposition (Name of cremator of other OWN UNIVE Center	1	Date	20c. Location Washing	- City or 1	
Baltil	permit. F Departm Importar any Injui		21. Signature of Funeral Service Licer		_	22. Name and Ad	dress of FacilityColpolis Rd.	Lumbia M	ortuary MD 20	Serv 706	vices, P.A.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do n	ot enter the mode of	tying, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Pneumonia							Oligot and Doali
	/Medical Examiner	ı	resulting in death)	Due to (or as a co	onsequence o	f):					
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2	res that the signed by be detact	Ď	Part II. Other significant conditions of Alzheimers Type		not resulting in	the underlying cause	given in Part I.	1	tobacco use cor		o the cause of death?
Records,	The law requires that the tte best bear signed by the page 2 should be detached	Completed	Alzhemers Typ	e bellericia				24a. Wa		Were au	utopsy findings available completion of cause of
a			25. Was case referred to medical	1			26 Place of De	1 ☐ Yes ath (Check only		1 🗌 Yes	2 □ No
<u>=</u>	F 2. 5	To Be	examiner?  1 Yes 2X No	Hospital:	2 ER/Ou	tpatient 3□ DOA				her (Spe	<sub>cify)</sub> Ass'd Liv
Division of Vital	Attending Phirideath. actor; After thiby the funeral		27. Manner of Death 1	28a. Date of Injury (Month, Day Y	(ear) 28b. T		njury at Work? 1 ☐ Yes 2 ☐ No		how injury occu		
Divis	2 th 2	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		- At home, fa Specify)	rm, street, factory, off	ce		(Street and Num own, State)	ber or Ru	ural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical (	29a. Certifier (Check only one) 1 Certifying Pl	hysician: To the best of r miner: On the basis of ex and manner stated	camination and	, death occurred at the	e time, date and plac ny opinion, death occ	e, and due to the curred at the time	e cause(s) and m a, date and place	anner as , and due	s stated. to the cause(s)
)	To the To the Complet	Ž	29b. Signature and title of certifier	Keill	y a	1D 29c. Lic	547 4	19	29d. Date sign		
			30. Name and address of person who	ycempleted cause of deal	0170	Type, Print)	se Ave	D-1,	Frene	Rh	et, und.
	St Regis	tate trar	31. Date filed (Month Day, Year)	2007 32. **gistrar's	Signature	Sperker		-			

			For State	State o	of Marylan	•	rtment of ⊢ <i>tificate of l</i>		Mental Hygid		
			Registrar  1. Decedent's Name (First, Middle,	I net)		001	incate or i	Death	2. Date of Death	<sup>1. No.</sup> 2 0 0 7	3. Time of Death
	Physicia	an	and the second						Month	Day Year	2 21 M
	/Medic		Mary Walsh Hale		<del></del>					5, 2007	3:21pm M
	Examin	er	4a. Facility Name (If not institution,	give street and nu	mber)			r Location of Death		4c. County of Dea	
			Suburban Hospit				Bethes If Under 1 Year	sda If Under 24 Hrs.	8. Date of Birth	Montgomer	
	Funeral		5. Social Security Number 077–30–6400	3. Sex 1 □ M 21x F	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	(Month, Day, )	rear) (	rthplace (State or Foreign Country)
	Director			-30	69	115.			Oct. 27,	1938 Nev	v York
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation				10d. Inside City Limits
	aryla shov d at	_	Toa. State Tob. County								1 ☐ Yes 2 XNo
	Ba-f s	cto	Maryland Montgo	mery	Roc	kville				633	)
	or 23	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What C	country?
	th w 23a ust b	a	209 Ritchie Par				20850			ited Stat	
	ems er m	Funeral	11. Marital Status	12. Was Dec	edent Ever in U orces?	I.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
٥	or It		1 ☐ Never Married 2K Marrie	If Yes, G	2 XINo ive		1 ☐ Yes 2 ☑ No	Specify:		Specify: Wh	ite
$\frac{3}{2}$	ours rral", Exa	d by	3 ☐ Widowed 4 ☐ Divorced	Year or E	Dates:	The state of					
215-0036	within 72 hours after death with the Maryland lene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	)	16a. Deced	tent's Usual Occup kind of work done	pation during most of worl d)	king	6b. Kind of Busines	s/industry
Z	ithin ne. nan '	ם	Elementary/Secondary (0-12)		(1-4or 5+)					Real Esta	ata
N	ed w ygier ier th	Ö		5+		Keal	Estate Ap	-	ne (First, Middle, M		110
/land	tal H	Be	17. Father's Name (First, Middle, L	ast)							
<u>8</u>	Men Men arke	၉	_Joseph Walsh							ine Muldo	
Mar	2 shc and is m		19a. Informant's Name/Relationshi	p (Type. Print)						City or Town, State	, Zip Code)
Ξ.	and and alth		Lawrence W. Hal	ey (Son)				ce, Rockv	ille, MD		
<u>S</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show among night or other traumatic event, the Medical Examiner must be notified at other.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demoval from	I	Place of Dispo cemetery, crei	sition (Name of matory or other pla	ce)	Date 2	0c. Location - City of	or Town, State
saitimore,	Page Int: II		4 □Donation 5 □ Other (Sp		St	. Mary'	s Cemete	ry 11/10			Maryland
Ē	mit.		21. Signature of Euneral Service	censee		1.0	2. Name and Addre	ess of Facility De	Vol Fune	ral Home	
ñ	Period		elect 1-	12/01		Ga	ithersbu	rg, MD 20	877		
57	H 444 B		23 a. Part1. Enfar the sase, or of shock, or he art failure. List of	complications at	caused the dea	th. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Dharatalan		Imme tete Couse (Final	nly one cause on	11 3 2 4						Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to	(o s a consec	unence of).	Pilotia	1 WIVY			
	Examiner			Duc to	P	11	н ( /	Failure	\		
		<u>-</u>	Sequentially list conditions,	b. Due to	(ur as a consex	quence of):	n CS	PENTABLE	v1)		
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
	and and al-tra	xar	that initiated events resulting in death) Last	c Due to	(or as a conse	quence of):					
8/60	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	a E									
8	cate phys	dical		d							
×	leath certific attending p I for use as	hysician/Me	IF FEMALE:	23c If yes o	utcome pf pregr	nancv				23d. Date of o	delivery
X R Q	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	tal death 3	Ectopic pregnanc Other (specify)	;y		Month	Day Year
	the a	sic	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9□Unki		death 5L	_ Other (specify) _				
J.	d by	Ph	Part II. Other significant conditio	as contributing to	death but not re-	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Ś.	w requires that the de been signed by the should be detached	ρ	M.:11.1 M	. I	Т		A 1.	1.1	1□ Ye	s 2□No 3□	Probably 4⊠Unknown
Hecords,	requi	Completed	- TIVINOLE III	Heloma.	<u> </u>	hemic_	Carenon	ye pathy			
Ů Ü	law as b	lg l	Siventricular	Failure	Sa	erol	decebity	<u>y</u>	24a. Was an autopsy	y Į prior t	autopsy findings available to completion of cause of
	The ate h	E O						-	perform 1□ Yes 2	ned? death ▼No 1 □ Y	
Vital	sician: The law certificate has b rector, page 2 s	Be C	25. Was case referred to medical					26. Place of Dea	ath (Check only one	9)	
	Physic this ce al direc	0	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1 🖃	Impatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	her: 4  Nursing H	lome 5 Reside	nce 6 Other (S	pecify)
0	g Ph ter th neral	Ë	27. Manner of Death	/8.60	e of Injury onth, Day Year)	28b. Time o	of 28c. Inju Wo	ry at ork?	28d. Describe ho	w injury occurred	
Division or	ath. rr: Af	atio	1 Natural 5 Pending 2 Accident investig	ation				]Yes 2□No			
<u> </u>	Atte	iji	3 Suicide 6 Could n 4 Homicide determi	200. Flat	ce of injury - At h	home, farm, st	reet, factory, office		28f. Location (Str City or Town		Rural Route Number,
5	s affe	Certification:			J (9F 99						<u> </u>
	hour hour ners y fille		29a. Certifier 1 Certifying	Physician: To the	ne best of my kn	nowledge, deal	th occurred at the t	time, date and place	e, and due to the ca	tuse(s) and manner ate and place, and o	as stated.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical I		nner stated.	ignor and/or II					
	To the withing To the Complex	Ž	29b. Signature and title of certifier	h	^			se number	29	d. Date signed (Mo	onth, Day, Year)
	5		1 + H. AK	-sh-	MD		0	0062167		11/5	107
			30. Name and address of person	vho completed car	use of death (Ite	em 23a) (Type,	Print)				
			Hossein Akhond:	L, M.D	8600 01	Ld Geor	getown R	oad, Beth	esda, MD	20814	
	Sta	ate	31. Date filed (Month, Day, Year)	2007 32	egistrar's Sigr	nature	lack .				
			MUV 0 9	ZUU/ /	The same of the sa	IN LA					

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month

30. Name and address of person who co

Ura

1 2007

29c. License number

21601

29d. Date signed (Month, Dav. Year)

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me 8874-12/17/07dhb For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Gloria Kennedy Holtery 8, 2007 6:50 a Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 🛛 F 5/4/1922 85 Director 169-14-2728 PA Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ms 23a or 28a-f shor r must be notified a 1X Yes 2 No Director Dunkirk MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2030 McCracken Drive 20754 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or items edical Examiner m Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: by 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the Insurance 12 Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be Russell Kennedy Beulah Tobias 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bertha Hungerbuhler/cousin 2030 McCracken Dr., Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 11/9/07 Beltsville, MD 22. Name and Address of Facility Raymond-Wood F.H., P.A. 21. Signature of Funeral Service Licensee PO Box 430, Dunkirk, MD 20754 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ulmonary emboli3m /Medical Due to (or as a consequency of): Examiner tracture Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner - stage Due to (or as a consequence of): burial 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pronths?

1 Yes 2 No 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 3e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? page mellitus Vital Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 **X**Yes <del>∕2 (3 √</del>0 Division or 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: <del>lat</del>ural 5 | Pending Unknown M 1 ☐ Yes 2 No investigation Subject fell out of bed 2 Accident 3 Suicide /07/2007 within 24 hours after death

To the Funeral Director:
completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 100 Hospital Road 6 ☐ Could not be determined 4 Homicide Hospital Prince Frederick, MD 1 🖫 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/08/2007 D60390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRINCE FREDERICK MO HOSPITAL RO. ABER 100 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28 2007 Heller tober /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner md21620 If Under 1 Year 8. Date of Birth (Month, Day, Year) Feb. 12, 1912 9. Birthplace (State or Foreign Age (In yrs. last birthday 6. Sex 5. Social Security Number New Jersey **Funeral** 1√ M 2□ F 95 521-01-1907 Director Usual Residence of Decedent 10d, Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County or items 23a or 28a-f show aminer must be notified at 1 √Yes 2 No Director Chestertown Maryland Kent 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be USA 21620 212 N. Queen Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 'Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Engineer U.S. Government ges 1 and 2 should be filed v it of Health and Mental Hygie If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Coyle Ira S. Heller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 212 N. Queen St. Chestertown, Maryland 21620 Peter Heller/ Son permit. Pages 1 au
Department of Hea
Important; If item;
any injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Oct.29,2007 Stevensville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Helfenbein, & Newnam Funeral Home PA r rd. Chestertown, MD 21620 130 Speer Kuk 23a. Part1. Enter the disease, or complic dons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 year Immediate Cause (Final disease or condition resulting in death) A 13 hermer

Due to (or as a consequence of): Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 3 Probably 4 Unknown 1 🗌 Yes 2 No DINTUPOTI Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed' 22 No 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 14 Inpatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

Division or Vital Records, P.O. Box 68760, the death certificate be Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

Certification: To filled in by the

within 24 ho To the Fune completely f ignatis State

the

24 hours a e Funeral I

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

4 ☐ Homicide

000

29c. License number D0050996 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Veil Studdard

determined

100 Brun r's Signature

MO

31. Date filed (Month, Day, Year)

32. Regis OCT 3 .0 2007

Registrar

			For State	State of M		partment of Hea		al Hygiene	007	37728
			Registrar  1. Decedent's Name (First, Mid	dle, Last)	Ce	ertificate of De	2. Da	Reg. No.		3. Time of Death
	Physici /Medio		-504ce	ANNE	HAIN	· T	/	Day 30	07	1:45 PM
+	Examin	er	4a. Facility Name (If not instituti	on, give street and number, R KOAA		4b. City, Town, or Local DULIN	town of Death	46.0	County of Death	Annes
	Funeral Director		5. Social Security Number	6. Sex 7. Ac	ge (In yrs. last birthday Yrs.		Under 24 Hrs. 8. Da ours Min.	te of Birth	9. Birth	nplace (State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. City, Town or I	ocation		1 -1.		10d. Inside City Limits
	Be-f sh	ector	MD Que	en Annes	QUEEL	HOWN				1 ☐ Yes 2 ☐ No
	h with ti	by Funeral Director	10e. Street and Number	e Road	·	10f. Zip Code	3	10g. Citiz	en of What Co	untry?
10	fter deal	Funer	11. Marital Status	12. Was Decedent Armed Forces arried 1 Yes 2X	Ever in U.S. 13	. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Y exican, Puerto Rican,	es or No- 1 etc.)	4. Race - Amer Black, White	
0036	hours after death with the Maryland turel', or Items 23a or 28e-f show at Exerctine or seek or officed at	d by	3 Widowed 4 Divorce	ed If Yes, Give Year or Dates:			oecify:		Specify: 6	ack
21215-0036	within 72 iene. then naith	Completed	(Specify only high Elementary/Secondary (0-12)	ent's Education nest grade completed) ) College (1-4or	(Giv	edent's Usual Occupation e kind of work done during DO NOT use retired)	g most of working	Ma	\\ \accelerates	1d'a
1d 21	e filed value Hygier other the	Be Co	17. Father's Name (First, Middle	e, Last)	710	18./	Mother's Name (First	, Middle, Maiden S	Sumame)	105
Maryland	2 should be and Mentat Is marked c	To	19a, Informant's Name/Relation	Eduard nship (Type, Print)	STEW	ling Address (Street 14)	VNDA J	E Number, City or	Town, State, Z	NCS Tip Code)
	mit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan serment of Health and Mental Hygiene. cortant: If item 27 is marked other than "natural", or items 23a or 28e-f show injury or other traumatic event, the Markinal Examinat or and the nutities at its injury or other traumatic avent, the Markinal Examination and the nutities at its.		Unia D.	Haines M	CHICL 128	AKERKO	t, Quel	NTOWN	, MD =	21658
Baltimore,	Pages 1 nent of H int: If ite		20a. Method of Disposition  1 Burial 2 Cremation 4 Donation 5 Other	n 3 Removal from State	1 comptant or	ematory or other place)	10/26/20	20c. Los 20 Ste W	Ition - City or	Town, State
Balti	permit. Pages Depertment of Important: If i sny injury or once.		21. So rtura of F noval Service	DIAACO		22. Name and Address of	Facility LW	Dales	DF 1	9904
*			23a. Part . Enter the disease, shock, or heart failure. Li	or complications that cause ist only one cause on each I	ine.			iratory arrest,		Approximate Interval Between
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O. Box	es thet the death certifica igned by the attending ph be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ☐ ☐ On the Property of the Prop		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			3d. Date of deli Month	Day Year
s, P.O.	Physician: The law requires thet the the this certificate has been signed by the director, page 2 should be detached.	by Ph	Part II. Other significant condi	itions contributing to death	out not resulting in the	underlying cause given in	Part I. 2	3e. Did tobacco us		the cause of death?
cord	w requir been s should	leted						1 ☐ Yes 2 6		obably 4 Unknown topsy findings available
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l Vita	ysician is certifi director	o Be	25. Was case referred to medic examiner?  1 Yes 2 No	Hospital:	ent 2 ER/Outpatie		Place of Death   Che   Nursing Home   5		□Other (Spe	cify)
o uc	ding Ph h. After thi funeral	ion: T	27. Manner of Death  Natural 5 Pendinger	28a. Date of Inj		of 28c. Injury at	28d. D	scribe how injury		
Division of Vital Record	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: Attercompletely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Coul	d not be 28e. Place of In	jury - At home, farm, s tc. (Specify)		28f. L.o	ocation (Street and ity or Town, State)		ral Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funsral Director: completely filled in by the		29a. Certifier Check only Medica	ying Physician: To the best al Examiner: On the basis of	of my knowledge, dea	ath occurred at the time, d	ate and place, and du	e to the cause(s)	and manner as	stated,
	To the H within 24 To the F complete	Medical	one) 29b. Signature and fitte of certifications	and manner s	tated.	29c. License nui	mber	29d. Date	signed (Monti	h, Day, Year)
	D		1 /8	Menn	N)	a, Print) Dorh W	37836	10	122/3	10)
			30. Name and address of person	Sorare.	death (Item 23a) (Type	Dork (br	u Che	, Lu Mi	1710	19
	Sta Registr	_	31. Date filed (Month, Day, Yea	3 0 2007 32. R	rar's Signature	diti				,

				Stack Indelible Ink. Ensure All		
			for State of Marylar	nd / Department of Health and Me	ntal Hygiene	2007 27720
			Registrar	Certificate of Death	Reg. No.	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Re+++++++++++++++++++++++++++++++++++	Hackett	Date of Death Month Day	Year 858 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
			201- Erin Way - Uni	+103 Reistertown	18	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24 Hrs. 8	. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		213-12-5443			124 Maryland
	and * -		Usual Residence of Decedent  10a. State 10b. County 10c. Ci	ty. Town or Location		10d. Inside City Limits
	Aaryl aho	5	MD Baltimore R	0104-1		1 PYes 2 □ No
)	the t	ect	10e. Street and Number	eistertown 101. Zip Code	10a, Citi	izen of What Country?
\	death with the Maryland ms 23a or 28a-f ahow rinust be notified at	Funeral Director	201- Erin Way- Unit 1	03 2/136		7/ 54
,	death ms 2:	ыега	11 Marital Status 12 Was Decedent Ever in U		ly Yes or No-	14. Race - American Indian,
0	after or Ite	Fur	Armed Forces?  1 Never Married 2 Married I Yes 2 12 No If Yes, Give		can, etc.)	Black, White, etc.
2000	hours after turn!, or Ita	d by	3	1 ☐ Yes 2 ☐ No Specify:		Specify: Black
ה	72 F B	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Ki	ind of Business/Industry
7	within ene. then "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	N	1.0 10-1 1:1
Z	Hygie ther t		17. Father's Name (First, Middle, Last)	Cafeteria Worker	First, Middle, Maiden	sumama)
ă	d be intal l	Be C	Martin Harris	Della	0 111	1
<u></u>	should and Me In mark	ို	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural F	Cotting	
Z Z	P 5 5 5		Sharon Hackett	0	+103 Reis	tertown MD. 21136
ē,	s 1 an f Heal fram 2 other		20a. Method of Disposition 20b. I	Place of Disposition (Name of Dat Semetery, crematory or other place)		ocation - City or J. wn, State
DE	Pages ment of ant: If it ury or o		1 E Burial 2 Cremation 3 Hemoval from State	augh Cemetery 11/6	107 Can	Abridge, MD.
<u>=</u>	arte parte		21. Signature of Funeral Service Licensee	22. Name and Address Facility Henry Fureral H	Lane C.A.	101.5997112
מ	Dep Impe	17	Janelle C. Herry	510 Washington S	to Cambr	idae, MD.21613
			23a. Park. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.			Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	Cancer		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consecutive conse			1000
	LXAIIIIIEI	_	Sequentially list conditions, b.			
	pe tist	ine	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	del of the		•
	be execut sicien and burial-tran	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consec	quence of):		
9		aiE	d			Janes Angla a - Y Aparanpar
00	leath certificate attending phys I for use as the	edic	100000000000000000000000000000000000000		100	112.00
X D D	~ ~ ~	N/W	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Feta			23d. Date of delivery
מ	death	sicia	1 Yes 2 No 4 Pregnant at time of c			Month Day Year
J.	at the	Physician/Medi	a Couknown			
s S	w requires that the death been signed by the atter should be detached for u		Part II. Other significant conditions contributing to death but not res Congrestive Heavy Fa		23e. Did tobacco u	use contribute to the cause of death?
5		eted	J /	11418	To tes 21	Mo 3 Probably 4 Onknown
Vital Records,	The law ste has b	Completed by	Hypertension		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	t: Th		Vascular Dementia		1□ Yes 2 No	1 Yes 2 No
=	slciar certif recto	Be	25. Was case referred to medical examiner?  1   Yes   2   Yoo   Hospital: 1   Inpatient   2	26. Place of Death N	7	
0	Phy or this oral d	. To	27. Manger of Death 28a. Date of Injury	28b. Time of 28c. Injury at 28	d. Describe how injur	
0	nding ath. r: Afte e fun	ation	1 ✓ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury Work?  M 1 Yes 2 No		
DIVISION	Atta actor by th	Certification:	2 Could not be		Location (Street an City or Town, State	d Number or Rural Route Number,
5	talor rs afte al Dir	Cer				
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only 2 Medical Examiner: On the basis of examina	owledge, death occurred at the time, date and place, an ation and/or investigation, in my opinion, death occurred	d due to the cause(s) at the time, date and	and manner as stated. If place, and due to the cause(s)
	thin 2 tha mplet	Med	29b. Signature and title of certifier	29c. License number		te signed (Month, Day, Year)
	F ≱ F 8		) for an	l l		
		30	30. Name and address of person who completed cause of death (Itel	m 23a) (Type, Print)	<del></del>	1 21284
			Alexander W. Chen and	PO Box 19099, Tou	uson, MI	21284
	Sta		31. Date filed (Month, Day Year) 9 2007 32. Restrar's Sign.			
	Registr	ar		No Market		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 6,14 per Ih, g875,01/28/08dhb

Certificate of Death

Bea No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2:30AM November Lupe Hovatter 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner litizens Nursing Home Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F Director 527-20-3352 83 08/28/1924 Arizona Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 28a-f show MD 1 ☐Yes 2 ☐ No Director Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 130 Weber Street U.S.A.

14. Race - American Indian Black, White, etc. death \ by Funeral 21078 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner Pages 1 and 2 should be filed within 72 hours after in the filed within and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 X Yes 2□ No Specify: Spanish Specify: 3 ₩ Widowed 4 Divorced Spanish Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Registered Nurse Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Rodolfo Ruiz ပ Refugia Cordova Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Jim Hovatter (Son) 132 Weber Street, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Harford Mem. Gardens : 11/17/2007 Aberdeen, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Mitchell Smith Funeral Home 123 S. Washington St., Havre de Grace, MD 21078 2 Part1. Enter the disease, or compile tion that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as ac onsequence of) Cornay /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dire to jor as a consequence of) mal Due to (or as a consequence burial-trar bvaffer, LUPe K, Division or Vital Records, P.O. Box 68760, irtusion the IF FEMALE yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Year Dav 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Osteswathrih 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performe Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 🔼 1 □ Ye Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manr 28a. Date of Injury (Month, Day Year) er of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Mo

Umion

mb

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 4 2007

Day Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Bernetta Jane Smith Hall /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 'ENTER regiona Medical NKEMIRS LISBURY eninsula 8. Date of Birth (Month, Day, Year) Sept 28, 1 der 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F 216-40-4681 65 1942 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Berlin Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 300 Maple Avenue 21811 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Black þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Various families 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abel S. Young Sarah Jane Adkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas I. Hall/husband 300 Maple Avenue, Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place)
Calvary UMC Cemetery 11/03/2007 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lewis N. Watson Funeral Home 21. Signature of Funeral Service License alare 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metabolic acidosis Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner cute Rena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed P515 burial-tran and Due to (or as a consequence of) physician Physician/Medical eumoni attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 > No 1 Tyes 3 Probably 4 Unknown funeral director, page 2 should 1POrtension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3□ DOA Certification: To this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 24 hours after death. filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

P.O. Box 68760. Division or Vital Records,

Baltimore, Maryland 21215-0036

within 2

State Registrar

Medical

2007

29b. Signature and title of certifique

Wilson Nines

29a. Certifier (Check only one)

Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Princessance MD 21875

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 0 7 37732 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month KERMIT PAGE HODGE 10:20 A M Nov 15, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4529 Flintville Road Whiteford Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 3/26/1935) 6. Sex 12 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 72 North Carolina 241-46-0882 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "naturel", or Iteme 23a or 28a-f ehor the Modical Examinar must be notified at 1 ☐ Yes 2 ☐XNo Whiteford Harford Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4529 Flintville Road 21160 USA Pages 1 and 2 should be filed within 72 hours efter death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Heavy Equipment Operator Ouarry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank James Hodge Emma Hazel Moxley ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a Important: If Item 27 Is any injury or other tree once. Odessa L. Hodge/Wife 4529 Flintville Road, Whiteford, MD 20b. Place of Disposition (Name of cometery crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Tabernacle Cemetery 11/19/2007 Whiteford, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, 600 Ma

234. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Harkins Funeral Home, 600 Main St., Delta, PA Approximate Interval Between Onset and Death Immediate Cause (Final Blad **Physician** disease or condition resulting in death) 01 real /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evidence) Due to (or as a sonsuquence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physicien and use as the burial-transit that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760,5 Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 2 No 3 Probably 4 □Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause ol death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificete 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Persidence 6 Other (Specify) ပ 1 Yes 2 No his After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Christying Physician: To the best of my knowledge, death oppured at the time date and blood, and due to the course(s) and manner as stated Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2. To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 15, 2007 DOC228412 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nood Road, Bel Ar MD 21014 32. Aegistrar's Signature Philiph 31. Date filed (Month, State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Mary Louise Hill 2007 jovember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ▼F Months Days Hours Min. 73 Yrs Director June 29,1934 MD 218-30-9771 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1X Yes 2 □ No Director MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Fulton Street Apt.3 21750 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced White Completed th and Mental Hygiene.
7 is marked other than "natul traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Retail Electronics Co-Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be fi Be Mary Reed Cleveland Shoemaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Donna Kay Weller/Daughter 14788 Buck Valley Road Warfordsburg, PA 17267 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot Orchard Ridge 11/18/2007 Hancock, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 141 West Main Street P.A. Hancock, MD 21750-0368 <u>Grove Funeral Home,</u> 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sepsis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Infarction Examiner Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed physician and s the burial-transit cancer Cenvical Division or Vital Records, P.O. Box 68760,答 Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: l or Attending Fatter death. 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1— Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) muhen 0060396

State Registrar

31. Date filed (Month, Day, Year)

FAR ID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MURSHED

2. Registrar's Signature

11/16/07

		For State Ragistrar					rtificate of	Health and M Death		Rag. No.	4001	3773
Physicia /Medica		1. Decedent's Name (Firs Gladys J							2. Date of De Month Novemb	per 1	6,2007	3. Time of Death 7:23 P
Examine	_	4a. Facility Name (If not it Williamspor			,		4b. City, Town, o	or Location of Death Sport	1		County of Death ashingto	on
Funeral Director		5. Social Security Numbe 227-10-5854	er 6. Se 1[		7. Age (In yrs.	last birthday) 92 Yrs.	If Under 1 Year Months Days		8. Date of Bi (Month, D January	T		place (State or Fore ntry) 7A
aryland show	ے		. County			y, Town or Lo						10d. Inside City Lim
ith the Marylan or 28a-f show	Director	MD Wa 10e. Street and Number	shingto	on	Wil	liamsp	10f. Zip Code			10g. Citi:	zen of What Cou	
eth with	ra D	154 Artiza	ın Stre				21795			USA		
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "neture!, or iteme 23a or 28a-f show any njury or other treumatic event, the Modified Examinar must be notified at page.	by Funeral	11. Marital Status  1 □ Never Married  3 ☑ Widowed 4 □ I		12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	2 🔯 No		Was Decedent of H If Yes, specify Cub  1 ☐ Yes 2 No	Hispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or N o Rican, etc.)		14. Race - Ameri Black, White, Specify: Whi	
Baltimore, Maryland 21215-0035  sernit. Peges I and 2 should be filled within 72 hours alt Department of Heelih and Mental Hyglene.  mportant: if item 27 is marked other then "neture!, or nny njury or other treumalic event, the Modical Exami Dice.	Completed		Decedent's Edu		4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of world)	rking	Non-	nd of Business/Ir Profit	
iled with Hygiene ther the nt, the	Com	17. Father's Name (First,		College (1º	401 54)	Seci	retary	18. Mother's Nan	ne /First Middle	1	nizatio	n
uid be i Mentai I irked o itic eve	To Be	Oscar C.		n				111	e C. Wel			
d 2 sho h and h 7 is ma treuma		19a. Informant's Name/F				•	,	and Number or Ru				p Code)
s 1 and of Heelt item 2		W. Lee Flen 20a. Method of Disposition	on C	-		Place of Dispe	4 MLLLSTO position (Name of matory or other pla	one Road I	Hancock Date		ZI/DU cation - City or T	own, State
t. Pege rtment c rtant: if		1 Burial 2 Cre 4 Donation 5 D	Other (Specify,	)	tate	lar La	m	11/20	0/2007		erstown,	
Department Important		21. Sonature Funeral	Service Licens	" Ply	0		2. Name and Addre	eral Home			Main Sta	
		23a. Part1. Enter the dis shock, or heart fail	ure. List only o	cations that ca	used the deat ich line.	h. Do not en	ter the mode of dyi	ng, such as cardiad				Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-		or as a conseq	uence of):	eumonic	<b>L</b>				Hdays
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ficate be executed physicien and s the burial-transit	Examiner	Sequentially list condition any, leading to immediately any, leading to immediately. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		. Alsh	TelMer or as a conseq	's Di	sease					years
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	Physician/Me	IF FEMALE: 23b. Was decedent precin the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	ths?		nth 2∏Feta antattime of c	al death 3	⊒Ectopic pregnanc □ Other (specify) _	ÿ			23d. Date of delive Month	very Day Year
w requires thet it	۾	Part II. Other significant	t conditions co	ontributing to de	ath but not res	sulting in the u	ınderiying cause gr	ven in Part I.		tobacco u	/	the cause of death
The law received has been page 2 sho	Completed								per	s an opsy formed? 2 No	prior to co	opsy findings availa omptetion of cause 2 \( \text{No} \)
alcien s certifi lirector	To Be	25. Was case referred to examiner? 1 ☐ Yes 2 No	-	Hospital:	npatient 2	EB/Outpatie	nt 3□ DOA Ot	26. Place of Dea			6 □Other (Spec	(6.1)
ng Phy After this	on: T	27. Manner of Death	☐ Pending	28a. Date o	·	28b. Time	of 28c, Inju	iry at ork?	28d. Describe			ny)
To the Hospital or Attending Physicien: The I within 24 hours after deeth.  To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	Certification:	2 Accident	investigation Could not be determined	280. Place	of Injury - At h		M 1 [	]Yes 2 □No		(Street an		ral Route Number,
Hospital 4 hours e Funerei Diely filled i	edical Ce	(Check only 2	Certifying Phy Medical Exam	iner: On the ba	isis of examina	owledge, dea ation and/or i	th occurred at the to	ime, date and place opinion, death occu	e, and due to th	e cause(s)	and manner as	stated. to the cause(s)
To the within 2 To the complet	Med	29b. Signature and title		and mann		b mD	29c. Licen	se number			te signed (Month	Day, Year)
1									101111			,
2		30. Name and address of Gynthia Ko	of person who	completed cause	of death (Ite	m 23a) (Type Lltams	Print) Nuc	sing Home	124 W	orth	Artizon	Street

ORIGINAL

			For State Registrer		State of M	aryland .	/ Depa	irtment of	Health	and M h	lental Hy	giene Reg. No	2007	37735
			Decedent's Name	(First, Middle, La	st)						2. Date of De	ath		3. Time of Death
	Physici /Medic		· mac	CHIA	1 stoi-	ora	in	H	by H		Month	Da	12 07	1230AM
	Examin		4a. Facility Name (If	not institution, giv				4b. City, Town	n, or Location	on of Death		40	. County of Dea	ith
			Benerly	Mun	gantar			11	erst		mD			ash
	Funeral		5. Social Security Nu	9	0x) 7. Ag	e (In yrs. last	t birthday) Yrs.	If Under 1 Ye Months Da		ler 24 Hrs. s Min.	8. Date of Bir (Month, Da	y, Year,	9. Bir	thplace (State or Foreign ountry)
	Director		Usual Residence of D	93		87	115.				July 5	, 19	920 Mai	cyland
	land ow			10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
	Many fed	ţ	Penna.	Frankl:	in	Gree	ncast	:le						1 ☐ Yes 2 🛣 No
	h the	Director	10e. Street and Num	ber				10f. Zip Cod	е			10g. Ci	itizen of What C	ountry?
	23e c	aiD	14519 Me	rcersbur	g Road			1	7225				USA	
Maryland 21215-0036	s within 72 hours after death with the Maryland liene. r than "netural", or Items 23e or 28e-f show The Medical Exant were use to confilled at	by Funerai I	11. Marital Status 1 □ Never Marrie 3 ☑ Widowed 4	_	12. Was Decedent Armed Forces? 1  Yes 2 If If Yes, Give Year or Dates:		į	Vas Decedent of Yes, specify C			ecify Yes or No Rican, etc.)	>-	14. Race - Am Black, Whi	
50	72 ho	ted		15. Decedent's E		1		lent's Usual Oc kind of work do		ost of work	ina	16b. h	Kind of Business	s/Industry
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7		ខ	11		0		h	ousewif					own hor	ne
and	T to o	Be	17. Father's Name (F Frank L.		,						e (First, Middle P. Malo		n Sumame)	
ž	s 1 and 2 should bit Health and Mentitem 27 is marked other traumatice	٦ ا	19a, Informant's Nar		Tuno Print		10b Mailie	a Address /Str					or Town, State,	Zin Codo)
Ma	d 2 s th an traur traur		Helen Ho											
	Health tem 27 other tra		20a. Method of Dispo		I III IAW	20b. Plac	e of Dispo	sition (Name of	ſ	gerst	Date		and 2174 ocation - City o	
Ö			1 XBurial 2 ☐	_	Removal from State	_		natory or other.  1 Cemet		11/1	5/07	Нас	raretown	n, Maryland
Baltimore,	permit. Page Department of Importent: If any injury of		21. Signature of Fun			1.080		. Name and Ad				_	NERAL HO	
ä	Per Imp		15g	ett	herry	M	4	15 E. W	ilson				own, Md.	
			23a. Part1. Enter the	e disease, or com	plications that cause one cause on each I	d the death. I								Approximate Interval Between
	Physician		Immediate Cause (F		D.o	WA DAL	His							Onset and Death
	/Medical		resulting in death)		Due to (or as	a consequen	nce of):							39-0913
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	₽ #	iner	Sequentially list con if any, leading to impresse. Enter Under Cause (Disease or in that initiated events	mediate lying	Due to (or as	a consequen	nce of):							
	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) La	ast	C	a consequen	on of							
8760,	be ex ician burial	ai E	,		Due to (or as	a consequen	100 01).							
87	phy	dicai		•	_ d		·							
.O. Box 6	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pregna Other (specify					23d. Date of de Month	elivery Day Year
<u>α</u>	ires that signed by I be deta	þ	Part II. Other signific	cant conditions	contributing to death t	out not resultin	ng in the u	nderlying cause	given in Pa	art I.		tobacco Yes 2		to the cause of death?
Vital Records,	e law requir has been si je 2 should l	Completed									24a. Was	s an	24b. Were a	autopsy findings available completion of cause of
= E		Con									perf 1 ☐ Yes	ormed? 2NN	death? lo 1 ☐ Ye	s 2 No
Vita	icien: Th certificate rector, pag	Be	25. Was case referre examiner?		Hospital:				26. P	ace of Deal	h (Check only	one)		
of	S 5 5	2	1 ☐ Yes 2 151. 27. Manner of Death	`	28a. Date of Inju		VOutpatier		41)	Nursing Ho	ome 5 Res		6 Other (Sp	ecify)
<u>_</u>		Certification:	Natural	5 Pending investigation	(Month, Da	y Year)	Injury		njury at Work? 1 ∐ Yes 2	□No	20d. Describe	now inj	ury occurred	
Division	ten leat tor: the	fica	2 ☐ Accident 3 ☐ Suicide	6 Could not b	9 Ole Diese of In	jury - At home	e, farm, str	eet, factory, off			28f. Location	(Street a	and Number or F	Rural Route Number,
Ö	afor, after Dire	erti	4  Homicide	dotomino	building, e	tc. (Specify)					City or To	wn, Sta	te)	
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical C	29a. Certifier (Check only one)	1 Certifying Pi	nysician: To the best miner: On the basis of and manner s	of examination	edge, deat n and/or in	n occurred at the vestigation, in r	e time, date ny opinion,	and place, death occur	and due to the red at the time	cause(	s) and manner a nd place, and du	as stated. ue to the cause(s)
)	To th withir To th comp	Me	29b. Signature and t	itle of certifier	gsus	4		29c. Lio	D 2	83E	-20		ate signed (Mor	
اك	H-Z		30. Name and addre	ss of person who	completed cause of DSHRP	death (Item 2:	3a) (Type,	Print)	tru	1 - N	agesto	nu	מח,	21740
	Sta Registi		31. Date filed (Monti		32. Regist	rar's Signatur		200			V			

P.O. Box 68760. Division or Vital Records. within 24 hours after death To the Funeral Director: To the Hospital

Saltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashish Tolia, MD

1500 Forest Glen Road, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

(Check only

Medical

State

Registrar

NOV 07

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D64588

29d. Date signed (Month, Day, Year)

November 1, 2007

			For State Registrar	State of Mar	-			nd Mental	Hygiene	e	
_		,	Registrar  1. Decedent's Name (First, Middle, Last)	-	Cei	rtificate	of Death	0.8-4-	Reg. No	2007	37737
	Physici	an						2. Date of Month Nover	Da	y 2007	08:57 AM
	/Medic		Eloise Rhudy Har  4a. Facility Name (If not institution, give s			4b. City. To	wn, or Location of			. County of Dea	
- 60	LAdiiii	ici	Calvert Manor Heal		nter		sing Sun			Cecil	
	Funeral Director		5. Social Security Number 6. Sex 212–50–4713	7. Age (	(In yrs. last birthday) Yrs.		Year If Under 24 Days Hours	4 Hrs. 8. Date of (Montal June	h. Dav. Year	9. Bir 917 V1	thplace (State or Foreign ountry) rginia
	P.		Usual Residence of Decedent			1					
	Marylau I-f show fled at	tor	Maryland Cecil		0c. City, Town or Lo	sing Su	ın				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th the	Jirec	10e. Street and Number			10f. Zip Co	ode		10g. Cit	tizen of What Co	ountry?
	ath wi	ral	1881 Telegraph Roa				911			ted Sta	
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Mediçal Examiner must be notitled at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Deceden If Yes, specify 1 ☐ Yes 2 ②	t of Hispanic Origi Cuban, Mexican, No <i>Specify:</i>	n? (Specify Yes of Puerto Rican, etc	or No-	14. Race - Ame Black, White Specify:	
21215-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual C	Occupation	-	16b. K	(ind of Business	/Industry
218	within 7 ene. than "r he Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	1		done during most or retired)	ot working			
	be filed within 72 ho ntal Hygiene. of other than "natule event, the Medical		12			Homemal		a Niama /Filad Ad			Home
lanc		To Be	17. Father's Name (First, Middle, Last)  James C. Rhudy					s Name (First, M. ary Kinse		Surname)	
Maryland	- F N 5		19a. Informant's Name/Relationship (Ty				treet and Number				
ē,	of Health Item 27 I		Claudia H. Peters  20a. Method of Disposition		20b. Place of Dispo cemetery, cre	nadow_I osition (Name matory or othe	of No	vember		nsy Ivan ocation - City or	ia 19317 Town, State
m	Page nent o ant: If any or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Hart's Co			2007	E1k	Neck,	Maryland
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other tonce.		21. Signature of Luperal Service License				Address of Facility				aryland21901
Ŗ.		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Betw									
4	Physician		Immediate Cause (Final disease or condition resulting in death)	Myo	cardial	Info	inction	)			Onse and Death
A.	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	A-31c a	enction coscleb	D(1 6			7
		ler	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):	N (NSV	USCLEU	9915			
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	)							
90,	oe exe cian a urial-l	I Ex	resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate b physic the b	dical		1.							
.O. Box (	at the death certifier by the attending partached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	3c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tii 9□Unknown	☐Fetal death 3 [	⊒Ectopic preg ⊒ Other (spec			100 000	23d. Date of de Month	livery Day Year
0	res that thigned by be detact		Part II. Other significant conditions cor	ntributing to death but	not resulting in the u	nderlying caus	se given in Part I.	23e.	Did tobacco	use contribute t	the cause of death?
Records,	The law requires that the law been signed by the lage 2 should be detache									robably 4 Unknown	
ecc	has bei	Completed						24a.	Was an autopsy	24b. Were a	utopsy findings available completion of cause of
R		Con						101	performed?	death? o 1 ☐ Yes	
Vital	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	lospital:			26. Place of	of Death (Check	only one)		
o		. To	1 Yes No F	1 ☐ Inpatient	2 ER/Outpatier		INurs	sing Home 5	Residence		ecify)
ion	Attending In death.  ector: After by the funer.	ation	1 Natural 5 ☐ Pending investigation	(Month, Day		М	. Injury at Work? 1 ☐ Yes 2 ☐ N		moo non mje	ny occurred	
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury building, etc.	/ - At home, farm, sti (Specify)	reet, factory, o	ffice	28f. Locat City o	ion (Street a or Town, Stat	nd Number or R e)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifler (Check only one)  Certifying Physical Certifying Physical Examiler  Medical Examiler	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	th occurred at ovestigation, in	the time, date and my opinion, deat	place, and due the occurred at the	the cause(s time, date ar	s) and manner and place, and du	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				icense number			ate signed (Mon	th, Day, Year)
			New E.du	7	<u> </u>	2	200283	554	1	1/7/0-	<b>†</b>
	4		30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Type,	Print)	500583	ing Sun	, MO	21911	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Degistrar	s Signature	parte	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 5, 2007 0222 **Physician** WILLIAM JOSEPH HICKS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. MARY'S CALIFORNIA 22420 CORNWALL DRIVE 6. Sex 1**X** M 2 □ F 8. Date of Birth Month Day, MAY 24, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours  $^{\gamma}$ 1 $^{\circ}$ 11 MARYLAND 218-09-4320 96 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ST. MARY'S CALIFORNIA 1 XYes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20619 UNITED STATES 22420 CORNWALL DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X1 Yes 2 \( \text{No} \) No 194

If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1943 1 ☐ Yes 21 No BLACK Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE WORKER FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GEORGE WILLIAM HICKS HARRIETT HICKS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22420 CORNWALL DRIVE, CALIFORNIA, MARYLAND 20619 19a. Informant's Name/Relationship (Type. Print) MARY QUEEN/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEMETERY: 11/08/2007 CHELTENHAM, MD 21. Signature of Funeral Service <sup>22</sup>THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 ANDIA C. THORNTON JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 robably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perform 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural Injury

Physician /Medical Examiner be executed burial-trar

**Funeral** 

Director

"natural", or Items 23a or 28a-f show

traumatic event, the Medic

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marked other

th and Mental Hv

permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any Injury or other trau

72 hours after

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division or Vital Records,

Examiner physician Physician/Medical the as JSe i the a signed by t 2 Completed certificate funeral director, Be this After t Certification: Hospital or Attendi 24 hours after death. Funeral Director; A death. filled in by

5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a, Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

(actifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address g

JENNIFER ACHMIDT, M.D., 40900 MERCHANTS LANE, SUITE 205, LEONARDTOWN, 20650 31. Date filed (Month, Day, Year)

State Registrar

Wedical

2007 NOV 07



24 hours a

within 2

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 Department of Health and Mental Hygin Important: If Item 27 is marked other any injury or other traumatic event, the once, ဂ္ Physician /Medical

**Physician** 

/Medical

10a, State

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Directo

Examiner-

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execute been signed be should be deta page 2 within 24 hours after death To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

a	9885 Greenbelt Road #103 A		207	/06		Uni	ited St	ates
nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, Whit	
To Be Completed by Funeral	1 □ Never Married 2 □ Married 1 □ Yes ₹ ☑ No If Yes, Give A Year or Dates:	1	□Yes 2√XNo	Specify:			Specify:	B1ack
letec	15. Decedent's Education (Specify only highest grade completed)	(Give k	nt's Usual Occup ind of work done	during most of wor	king	16b. Kii	nd of Business/	/Industry
omp	Elementary/Secondary (0-12) College (1-4or 5+)		er Servi	·		Banl	king	
C	17. Father's Name (First, Middle, Last)				ne (First, Middle,	Maiden	Surname)	
O B	Louis Ryan			Mary Alb	ritton			
П	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing	Address (Street	and Number or Ru	ıral Route Numbe	er, City o	r Town, State, 2	Zip Code)
	Doyle M. Irons / Son	740	Melglory	Rose Co	ourt Sto	ckb:	ridge,	GA 30281
	20a. Method of Disposition  20b. Plac  20b. Plac  20c. Method of Disposition  3 Removal from State	e of Disposi netery, crema	tion (Name of atory or other place	ce)	Date	20c. Lo	cation - City or	Town, State
	4 Donation 5 Other (Specify) MD Na	ationa	1 Mem. F	Park 11/0	5/2007	Lau	rel, Ma	ryland
	21. Signature of fluneral Service Licensee	22.	Name and Addre	ss of Facility Si	mple Tr	ibut	е	
	Wy y						e, Mary	land 20852
	23a. Part1. Prior the disease, or complications that caused the death. I shock or heart failure. List only one cause on each line.	Do not enter	the mode of dyin	ng, such as cardiad	or respiratory ar	rest,		Approximate Interval Between
	Immediate Consessive He	eart F	ailure,	End Stag	e			Onset and Death Months
	resulting in death)  Due to (or as a consequent							
_	Sequentially list conditions, b. Hypertension							Years
ine	cause. Enter Underlying	ice of):						
кат	Cause (Disease or injury that initiated events resulting in death) Last							
a E	Due to (or as a consequent	ice or):						
dic	d							
N.	IF FEMALE: 23c. If yes, outcome pf pregnance	y					23d Data of da	livon
ciar	23b. Was decedent pregnant in the past 12 months?		ctopic pregnancy Other (specify)			1	23d. Date of del Month	Day Year
hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of deat							
y P	Part II. Other significant conditions contributing to death but not resulting	ng in the und	erlying cause give	en in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
Completed by Physician/Medical Examiner					1 □ Y	es 2	□No 3□Pr	robably 4XXUnknown
plet					24a. Was a		24b. Were at	utopsy findings available completion of cause of
E O					perfor	med?	death?	•
Be	25. Was case referred to medical examiner?			26. Place of Dea	th Check onl or			
	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER	l/Outpatient	3 DOA Oth	er: 4 ☐ Nursing H	ome XX Resid	ence 6	3 □Other (Spe	cify)
ation: To	27. Manner of Death  1XX Natural 5 □ Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)	3b. Time of Injury	28c. Injur Worl	y at k?	28d. Describe h			
Satio	2 Accident investigation		M 1	Yes 2 □ No				
ij	3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (S City or Tow	treet and n, State	d Number or Ru )	ural Route Number,
ပ္ပ	VY Control Division To the Control of the Control o				<u> </u>			
Medical Certific	29a. Certifier XXX Certifying Physician: To the best of my knowle (Check only one) Medical Examiner: On the basis of examination and manner stated.	age, death on and/or inve	estigation, in my o	ne, date and place pinion, death occu	r, and due to the d rred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
Me	29b. Signature and title of certified	ta.	29c. License	e number		29d. Date	e signed (Mont	h, Day, Year)
	Chief Medical Officer - Hospice of the Ch	necareal	re 1	D 21438		Λ	101/05	, 2007
	30. Name and address of person who completed cause of death (Item 23)			D 21430		, ,	00	1 /.
	Michael J. LaPenta, M.D., 445 D	efens	e Highwa	y. Annap	olis. Ma	ryla	nd_2140	01

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 6,2007 22:02M Amir November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Hopkins Hospital Johns If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funerai 1 XM 2 ☐ F Months 39 NOV 2, Director 119-80-2152 1968 Pakistan Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County show must be notified at 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 7737 Rotherham Drive "natural", or items 23a 21076 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after di Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 2 Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Technology 5+Computer Scientist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Muhmmad Ikram Nasim Begum ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shahid Ikram/Brother 23 Old Laxfield Rd., Shrewsberry, MA 01545 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Nat'l Mem. Park 11/7/2007 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thibadeau Mortuary Service, P.A. 933 Gist Ave., LL, Silver Spring, MD Brim Min M01508 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Glioblastoma **Physician** years /Medical Due to (or as a consequence of): **Examiner** ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit ntraventricular Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by t should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ashwini Davison, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287 32. Segistrar's Signature

Vansen Medical Doctor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

November

6 2007

		For State Registrar	mbd # 31 '	State of Per PG, oc			rtment of H tificate of I	lealth and N D <i>eath</i>	-	giene Reg. No	2007	37741
Physicia	ın	1. Decedent's Name	e (First, Middle, La	ist)	11/5/07		-		2. Date of De Month	ath Day	Year	3. Time of Death
/Medic Examin	al - er	CATHERIN] 4a. Facility Name (If	not institution, given				4b. City, Town, or	Location of Death	NOVEMBE		2007 County of Death	11:00 A
		SOUTHERN N 5. Social Security N			Age (In yrs.	(ast hirthday)	CLINTON If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		INCE GEO	ORGE'S place (State or Foreign
Funeral Director		578-64-77	725	1 □ M 2 🛣 F		3 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Cour	esda MD
yland now at		Usual Residence of 10a. State	10b. County			y, Town or Lo	cation				1	10d. Inside City Limits
the Mar 28a-f sl	Director	MD 10e. Street and Nun	PRINCE (	EURGE'S	CL	INTON	106 Zin Code			10a Citiz	en of What Cour	1)X Yes 2 □ No
th with 1 23a or 3 ist be n		9106 PIN		ANE			10f. Zip Code 20735				TED STAT	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 □ Never Marri	ed 2X1 Married	12. Was Deced Armed Forc 1  Yes 2			Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	1	4. Race - Americ Black, White,	
ural", or	þ	3 Widowed	4 Divorced	If Yes, Give Year or Date	_		☐ Yes 21X0 No	Specify:			Specify: BLA	
hin 72 h	Completed	(Spec	15. Decedent's E lify only highest gr ndary (0-12)	ducation ade completed) College (1-4	or 5+)	16a. Deced (Give life. L	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of worl l)	king	16b. Kin	d of Business/In	dustry
filed with Hygiene ther the nt, the	Com	12th 17. Father's Name (	1				NU	RSING ASS		NURS Maiden S	72:10	
Mental Mental srked o	To Be	JAMES	KING					EVIA L.	, ,			
d 2 sho th and I ?7 is me traums		19a. Informant's Na	•				g Address (Street				•	,
of Heal of Heal		20a. Method of Disp	osition	Removal from St	1 4	15407 Place of Disponentery, cren	NORLINDA sition (Name of natory or other plac	CIRCLE C	DAON HIL Date	L MI 20c. Loc	2074 eation - City or To	.5 own, State
artment ortant: Injury o			5 Other (Speci	fy)	MT.		T CEMETER		.3/07	WASH	HINGTON,	D.C. 20002
Dep Imp any		Ma	112 40	hor	Isl							N.E. WASH.
Dhuaisian		23a. Par 1. Enter the shock, or hear the shock of hear the shock of th		nplications that cau one cause on eac	ised the deat If line.	n. Of not ente	er the mode of dyir	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause ( disease or condition resulting in death)	" <i>"</i>	a. Due to (or	as a consequ	uence of):	174					V4.75
Examiner	er	Sequentially list cor if any, leading to im	nditions, imediate	b. Due to (or	as a conseq	uence of):						
te be executed ysician and ie burial-transit	Examiner	Cause (Disease or that initiated events resulting in death) L	injury	C	as a conseq	uanga of):						
icate be executed physician and s the burial-transit	edical E		•	_d	ao a <b>co</b> nocq							
ph sth		IF FEMALE:		23c. If yes, outco	me of pregna	IDCV					Od Data of dallin	
atte for	sician/M	23b. Was decedent in the past 12 1 \sum Yes 2 \overline{1}	months?	1 ☐ Live birt	h 2 ☐ Feta nt at time of d	Ideath 3□	Ectopic pregnancy Other (specify)				3d. Date of delive Month	Day Year
res that the igned by the be detach	, Physi	9 ☐ Unknown Part II. Other signif	,			ulting in the ur	nderlying cause giv	en in Part I.	23e. Did 1	tobacco us	se contribute to t	the cause of death?
w requires been sign should be	ted by	PUL	MONAN	y ENN	3021	M			10	Yes 2	¶No 3□Prol	bably 4 □Unknown
ne law r has be ge 2 sh	Completed	AN	EMA	•					24a. Was auto perfe		24b. Were auto prior to co death?	opsy findings available ompletion of cause of
	Be Co	25. Was case referrexaminer?	red to medical					26. Place of Dea	1☐ Yes	2 No	1 🗆 Yes	2√€ No
Physic r this ce	၉	1 Yes 2		Hospital: 1 Inplication 1 28a. Date of		ER/Outpatien		4 ☐ Nursing H	ome 5 ☐ Resi		☐Other (Special	fy)
or Attending Physician: fter deam. Irector: After this certific in by the funeral director.	ation	1 Natural 2 Accident	5 ☐ Pending investigation 6 ☐ Could not the	n	Day Year)	Injury	28c. Injur Wor M 1 □	k? Yes 2 □ No				
al or Attend after death.	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place o	f injury - At ho , etc. <i>(Specif</i>	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and wn, State)	d Number or Run	al Route Number,
To the Hospital or Attens within 24 hours after dear To the Funeral Jirecton: completely filled in by the	Medical C	29a. Certifier (Check only one)		hysician: To the b miner: On the bas and manne	is of examina							
Vorthii	Me	29b. Signature and	title of certifier			_	29c. Licens				e signed (Month,	
8)		P. WISC	ess of person who	completed cause	of death (Item	23a) (Type,	A 1/1/C	CENTOR	WAC	DENO	F. let.	- 5, 2007 2060Z
Sta Registr		31. Date filed Work	10 V () Year) 74		gistrar's Signa	-					•	
MH 17 Bey 1/20		110	A A O FOL	Cha	w D	Spe	200					

State of Maryland / Department of Health and Mental Hygiens, 1 - For State Registrar 37742 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov. 5, 2007 **Physician** 1:20p Joshi Victor /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac Valley Nursing Home Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/17/1932 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1-√M 2□ F Months India 220-60-0619 74 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County worle in than "natural, or iteme 23e or 28a-f ehover the Medical Examiner must be notified at Rockville 1 ☐ Yes 2 No MD Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #101 USA 20851 Twinbrook Parkway 13201 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Exemples. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Asian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Typesetter Newspaper Co. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Shakuntala Venkatara Venkatara Govandrae ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20851 Olga Joshi/Wife 13201 Twinbrook Parkway #101 Rockville, Md. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 11/08/2007 Beltsville, Md. C 4 ☐ Donation 5 ☐ Other (Specify 21. Signatura of Juneral Service Line PHITTPO ADJUSTICALDI FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9241 Columbia Blvd.Silver Spring,Md20910 Approximate Interval Between Onset and Death 15wks Immediate Cause (Final disease or condition resulting in death) Physician Myocardial infarction /Medical Due to (or as a consequence of) Examiner Congestive heart failure weeks Sequentially list our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Physician/Medical Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed years Athorosclerotic heart disease Due to (or as a consequence of): Box 68760. the use as I IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown diabetes mellitus chronic obstructive lung disease 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy rmea? 2 No certificate 1 Tyes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Japitar A hours after dec.
--ral Director: After 5 Pending М 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Nov. 7, 2007 29b. Signature and title of certifier 29c. License number 3 uman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman Tuli Gaithersburg, Maryland MD 10810 Darnestown Rd. 31. Date filed (Man) Cay. egistrar's Signature State 9 2007 Registrar

DHMH 17 Rev 1/2001

filed (Month, Day, Year)

3 200

31. Date

State Registr<u>ar</u> 32. Registrar's Signature

AS 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 17 37744 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician Virginia C. Johnson 2014 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Talbot Easton Memorial Hospita If Under 1 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country)
 PA **Funeral** Months Days 1 M 200 75 Director 221-20-1727 May 7, 1932 Philadelphia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show Funeral Director MD Kent Galena 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 13870 Massey Road 21635 U.S.A. th and Mental Hygiene. 27 Is marked other than "natural", or Items traumatic event, the Medical Examiner mi 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2☐ Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2000 Specify: Specify: White <u>م</u> 3 Widowed 4 Divorced ohnson, Uirginia Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian Education 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dana E. Carmer Merle Rose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important; if item 27 I any Injury or other tra of Health Anthony Johnson 13870 Massey Rd., Galena, MD21635 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Old St. Anne's 11/2/2007 Middletown, DE of Funeral Servio 22. Name and Address of Facility Robert DANIELS & HUTCHISON FUNERAL HOME LLC 212 N. Broad St. Middletown, ath. I not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications the caused the shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PLEURAL EFFUSSION MALICNANT WEEKS /Medical Due to (or as a consequence of): Examiner FAILURE CONGESTIVE HEART WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) The law requires that the death certificate be executed RESPIRATORY FAILURE DAYS that initiated events resulting in death) Last attending physician and for use as the burlal-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CLEAVED CELL 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed death? 2 No 2 NO 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To funeral e Hospital or Attending Pl 24 hours after death. e Funeral Director; After the etely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 66441 HD tilanum OCTOBER 27 2007

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ISOLLI RAMESH 219S WASHINGTON STREET, EASTON, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 37745 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year 5:45 am 07 Etta Virginia JOHNSTON 2 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hagerstown
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 312 Bryan Place Washington

**Funeral** Director

**Physician** 

/Medical

Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mentel Hyglene. Important: if item 27 is marked other then "naturel", or items 23s or 28s-1 show any injury or other traumatic event, it a Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

ral		5. Social Security Number	6. Sex	7. Age (In yrs. I	• • • • • • • • • • • • • • • • • • • •	If Under Months	1 Year Days	If Under Hours	24 Hrs. g Min.	3. Date of Bir (Month, Da	th v. Year)	Birthplace (State or Foreign Country)
or		218-34-2886	1 □ M 2 🟋 F	68	Yrs.						23 1939	
	-	Usual Residence of Decedent		10- 07	. T							40.11.11.02.11.2
	ا پ	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Director	Maryland Wash	ington		Has	gerst	own_					1 ▼Yes 2 No
	le E	10e. Street and Number				10f. Zip					10g. Citizen of	What Country?
	<u> </u>	312 Bryan Plac	e				2	1740			Ī	JSA
	Funeral	11. Marital Status	12. Was De	edent Ever in U.	S. 13.	Was Deced			igin? (Speci	ify Yes or No ican, etc.)		ce - American Indian,
	፣	1 ☐ Never Married 2 🔯 Mar	ned 1 ☐ Yes	2 X No						ican, etc.)		ick, White, etc.
	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or			1 ☐ Yes	21A) No	Ѕресну:			Speci	<sup>fy:</sup> White
	Completed		nt's Education		16a. Dece	dent's Usua	I Occupa	ation	t of working	_	16b. Kind of E	Business/Industry
	E P	Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	life.	DO NOT us	e retired	idring mos	t or working	,		
	0	9	0		Co-	-owner	r				Grocer	y Store
	ge	17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name (	First, Middle	Maiden Suma	me)
	0	Edward House	r					An	na E.	Jones	:	
		19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street a					, State, Zip Code)
		Vicky Harrel	1 - Daugh	ter	178/	7 Cart	- 020 - 1	[ ano	Цало	reterm	Marri 1	and 21740
	1	20a. Method of Disposition	I - Daugii	20b. P	lace of Dispo	sition (Nan	ne of		Dat			· City or Town, State
		1 € Burial 2 ☐ Cremation		1 State	emetery, crei	-			/	107		
	1	4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service		Boo	nsbor	) Ceme	etery	y of Facility	11/15	/07	Boonsbo	oro, Maryland
Duce		21. Signature of Purietal Service	2 /)-								uneral	
-	-	Jeasen Sel	andre									Md. 21740
		23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that t only one cause on	each line.						respiratory a	rrest.	Approximate Interval Between Onset and Death
an		Immediate Cause (Final disease or condition	2	elnon	u o	loss	vel	u ,	lung	Di	from.	Onset and Death
al		resulting in death)	Due to	(or as a consequ	ience of):	1			8			
er		Conventially list conditions	h	Cor	m	mus	ner	le				
	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consequ	Jence of):							
	Ē	that initiated events	<b>)</b> .									
ı	Examiner	resulting in death) Last	Due to	(or as a consequ	uence of):							
	Z Z		d									
	9											
1	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregna	ncy	70.					23d. Da	ate of delivery
	200	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Preg	birth 2 Fetal mant at time of de		Ectopic pro Other (sp.					М	onth Day Year
	) A	9 Unknown	9□ Unki	nown								
1	eted by Physician/Medical	Part II. Other significant conditi	ons contributing to	death but not resu	Ilting in the u	nderlying c	ause give	n in Part I		23e. Did t	obacco use con	tribute to the cause of death?
	9									130	Yes 2□No	3 ☐ Probably 4 ☐Unknown
	ale									04- 146-	24	Man auton Endon un labia
	E									24a. Was	osy ormed?	Were autopsy findings available prior to completion of cause of death?
6	E CONTRIBUTION									1 ☐ Yes	2☐No	1 ☐ Yes 2 ☐ No
ć	0	25. Was case referred to medica examiner?	Hospital:				1 04		of Death (	Check only o	оле)	
	2	1 Yes 2 No	1		ER/Outpatier			4 🗆 140			dence 6 🗆 Ot	
	5	27. Manner of Death 1 ☑Natural 5 ☐ Pendir	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury		8c. Injury Work	(?		d. Describe	how injury occu	rred
	2	2 ☐ Accident investi	igation			М	10	Yes 2 🗌	No			
		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Plac	e of Injury - At ho ding, etc. (Specify	me, farm, str	reet, factory	, office		28	If Location ( City or To	Street and Num	ber or Rural Route Number,
	ě				<u> </u>							
	2	29a. Certifier 1 Certifyin	ng Physician: To the	e best of my know	wiedge, deat	h occurred	at the tim	e, date an	d place, an	d due to the	cause(s) and m	anner as stated. and due to the cause(s)
	medical Certification; 10	one)	and ma	nner stated.	ion and/or in	vestigation,	in my op	oinion, dea	IIII OCCUFFED	at the time.	date and place,	and due to the cause(s)
1	₹	29b. Signature and title of certifie	or .					number	0		-	ed (Month, Day, Year)
				>		1	60	221.	8/18	8	11/	12/07
-		30. Name PA dre s		use of eath (Item	23a) (Type,	Print)	CAP	7/0	0,00	2.0		
		12821		ILL A	VE	MI	6.	m	P.	217	7 Cm 1	Kalim Ahmed
State		31. Date filed (Month, Day, Year, NOV 1		<b>Be</b> gistrar's Signat		<i>f</i>					DI. I	ATTII AIIIIEU
istra		MOA T	4 2007	Sellage 1	Or S	2133						

Registrar

BH-L

Amend Items 25,27,28a-f per we 874,12/1-7/07dhb

State of Maryland / Department of Health and Mental Hygiene O 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 3:38 am<sup>™</sup> Kirst November 12, 2007 Glanville Harry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months **XX**M 2□ F Yrs. Director 220-42-4720 1-22-1917 90 Wisconsin Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Solomons Maryland Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20688 United States 11740 Asbury Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify ۵ 3XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 12 Accountant permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If Item 27 is marked other I any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lila Glanville John Kirst ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26110 Woodridge Drive, Mechanicsville, MD 20659 Dot Sparling / Step-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Brinsfield-Echols Cr. 11-16-2007 | Charlotte Hall, Maryland 4 Donation 5 Dother (Specify) Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinstield, 22955 Hollywood Rd., Leonardtown, MD 20650-0279 (Jr M00052 LEATHECH THE APPROVED BY MEDICAL EXAMINER TO S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ysician 4504/2 ledical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2□ No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes <del>2</del> □ 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury

Found of Injury

Pound of Injury

Po 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 D Natural 5 Pending investigation 3√No 1 Tyes 2X Accident 06/2007 e. Place of injury - At home building, etc. (Specify) Probable multiple falls within 24 hours after deatl To the Funeral Director; Unknown 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Found: 11740 Asbury et, factory, office 4 ☐ Homicide Found: Apartment To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Hospital Road, Prince Frederick, Maryland 20678 Manoj Mathur, M.D., 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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tillore, maryland 21213-0030	172 hours after death with the Maryland	rtment of Health and Mental Hygiene.	"natural", or items 23a or 28a-f show	jury or other traumatic event, the Medical Examiner must be notified at

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Theodora 5:45 A M Kuzmowycz November 6, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert County Nursing Center Prince Frederick 8. Date of Birth (Month, Day, Year) 08–02–1916 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) al Months Days Hours 1 □ M 2 💢 F 199-28-2341 91 Poland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo PA Montgomery Jenkintown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 668 Forrest Avenue 19046-3342 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white þ A 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist/ Chemist Medical Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Musiejowski Helen P Lesyk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha D. Cenko, daughter 3125 Hickory Ridge Road, Dunkirk, MD 20754 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State Mary's Cemetery 11-09-2007 Elkins Park, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee Depar Depar Impor any Ir 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arrhythmic **Physician** Cardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardio Vascular disease thero sclenotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Linknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ tibn'nation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Vascular disease Peripheral 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No Cerebro vasulaz 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ို 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 50653 Swanco 11-6-2007 GYAN SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . C JRW 15 5851-Deale Churchton 20757 ROUGH 32. Registra Signature 31. Date filed (Month, Day, State NO 2007

Registrar

laryland

**Physician** Jay Daniel Kitts /Medical 4a. Facility Name (If not institution, give street and number) Examiner Civisto-5. Social Security Number **Funeral** 214-58-0096 Usual Residence of Decedent Director with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any lujury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director Maryland Charles 10e. Street and Number 12 Elder Place Funeral 11. Marital Status 1 Never Married 2 Married þ 3 Widowed 4 Divorced Be Completed Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Jolly H. ပ 19a. Informant's Name/Relationship (Type. Print) Jeffery C. Kitts, Sr. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 23a. Part 1. Enter the sease, or complications it all caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear allure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed use as the burial-trai nding physician Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be ို this 27. Manner of Death 1 X Natural Certification: or Attending n 24 hours after death.

ne Funeral Director: A
pletely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) November 6,2007 -61614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) swite 304 / Pembrook Square Sindhwani MD 11350 State NOV 0 9 2007 Registrar

		For	State	of Maryl	,	artment of F		lental Hyg	giene					
		State Registrar	Reg. No. 2											
Physici	an	Decedent's Name (First, Midd	le, Last)	2. Date of Dea Month										
/Medic		Doris Jeanne	Koski		7									
Examin	ier	4a. Facility Name (If not institution		i number)			r Location of Death			y of Death	. ,			
Funeral		College View No. 5. Social Security Number	6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year			n	Frede: 9. Birthp	place (State or Foreign			
Director		373-36-9153	1 □ M 2 🔀			Months Days	Hours Min.	(Month, Day July 21		Cour	ntry) nigan			
P.	١	Usual Residence of Decedent						10 ULY 2-1	, 1))/					
arylar show	Ľ	10a. State 10b. County	1	100	. City, Town or Lo	ocation				1	I0d. Inside City Limits 1 ☐ Yes 2 ☑ No			
he Mi	Director	Maryland Mont	tgomery		Poolesvi				10g. Citizen of	M/hat Cour				
with t a or 2						10f. Zip Code	20027							
leath ns 23 musi	Funeral	19550 Fisher A	12. Was I	Decedent Ever	in U.S. 13.	Was Decedent of H	20837 Hispanic Origin? (Sp	pecify Yes or No-		ed Sta				
after or iter		1 ☐ Never Married 2 ☐ Ma	rried 1 □ Y	d Forces? ′es 2 X No	1			o Rican, etc.)		ack, White,	etc.			
ral", c	b	3 X Widowed 4 ☐ Divorce	d Year	, Give or Dates:		1 □ Yes 2 ☑ No	Specify:		Speci		nite			
72 h 72 h	Completed	15. Decede (Specify only high	nt's Education est grade complet	ted)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wor	king	16b. Kind of E	Business/In	:s/Industry			
within within ane.	E I	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+)	iife.				77.1	ucation				
If it is in 2-0000.  If ide within 72 hours after death with the Maryland Hygiene.  If it is in a interest in the interest in a		12 17. Father's Name ( <i>First, Middle</i>	 , Last)			House Mot	18. Mother's Nam	ne (First, Middle,						
all ylalli should be ind Mental s marked o umatic eve	o Be	Elmer Andrew Mo	onk				Olive Cr	ook	, , , , , , , , , , , , , , , , , , , ,					
ges 1 and 2 should be filed within 72 hours after death with the Marylar ges 1 and 2 should be filed within 72 hours after death with the Marylar tof Health and Mental Hyglene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Elmer Andrew Monk Olive Crook  19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City o										or Town, State, Zip Code)			
and 2 and 2 salth a 27 is er tra		Barbara J. Kle	imola/ D	aughter	19550	) Fisher	Avenue, P	oolesvil	lle, Ma	rylan	d 20837			
of Henrich Control		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal f		Ob. Place of Disponentery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location	- City or To	own, State			
mit. Pages partment of portant: If it portant: If it it it in or or or or or or or or or or or or or		4 □ Donation 5 □ Other (	Specify)			Cremator		8/2007	Freder	ick,	Maryland			
Definition of the permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other trau		21. Signature of Funeral Service	e Licensee	mild	′ / St	2. Name and Addre auffer Fi	uneraI Ho							
4 402.00		220 Part I Enter the disease	JAJ9	nat caused the						Mary	1and 21702			
		23a. Part1. Enter the disease, on shock, or heart failure. List Immediate Cause (Final	st only one c	on each line.	death, bolloten	ter the mode of dyn	ng, such as cardiac	or respiratory ar	1631,		Approximate Interval Between Onset and Death			
Physician /Medical		disease or condition resulting in death)	a	e to (or as a co	nsequence (f):	pathy				-				
Examiner			500	2 to (01 as a col	/ D	J								
	声	Sequentially list conditions, if any, leading to immediate	b. 00	e to (or as a co	nsequence of):									
cuted nd ransii	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c											
of ou, cate be executed bhysician and the burial-transit	Ĕ	resulting in death) Last	Du	e to (or as a co	nsequence of):									
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± pai	Physician/Me	IF FEMALE:	23c. If ves	s, outcome pf pi	regnancy				234 D	ate of deliv	ven/			
death cer attendir	cian	23b. Was decedent pregnant in the past 12 months?	1 <u>0</u> L	ive birth 2  Pregnant at time	Fetal death 3	□Ectopic pregnanc □ Other <i>(specify)</i> _	у			Month	Day Year			
w requires that the de been signed by the should be detached	hysi	1	9□∟	Jnknown										
s tha	by P	Part II. Other significant condi	tions contributing	to death but no	t resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use co	ntribute to t	the cause of death?			
w requires been signed should be								1 🗆 '	Yes 2 → No	3 Pro	bably 4 □Unknown			
law ras be	plet							24a. Was	osv	. Were auto	opsy findings available ompletion of cause of			
VICAL DEC Societion: The law scerificate has to lirector, page 2 s	Completed	E performed death?  1□ Yes 2□ No 1□ Yes 2□ No												
VICAL Ician: T Sertificat ector, pa	Be	25. Was case referred to medic examiner?	Hospital:			041		ath (Check only c						
VISION OF VICE Attending Physician: r death. ector: After this certific by the funeral director,	은	1 Yes 2 No 27. Manner of Death		1 ☐ Inpatient  Date of Injury	2 ER/Outpatie	III SLI DOA		ome 5 Resident			fy)			
ding h. After funer	tion	1. Natural 5 ☐ Pend		(Month, Day Ye		Wo	rk? ]Yes 2∐No	200. Describe i	now injury occi	anca				
Atten Atten deat deat sector:	fica	3 Suicide 6 Could	d not be 28e. F	Place of injury	At home, farm, s	l treet, factory, office				nber or Run	al Route Number,			
s after sell or  Certification:	4 ☐ Homicide		building, etc. (S	pecny)			City or Tou	wn, State)						
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	_					th occurred at the t								
the h	Medical	one)  29b. Signature and title of certif	and	manner stated.		29c. Licen			29d. Date sigr					
T wil		255. Signature and title of Certif	c mD							7 . 5	207			
^'		30. Name and address of person	on who completed	cause of death	(Item 23a) (Type	Print)	060417		11 /	20	21702			
30		110.	hah A	ND, C	5 C T	homas	Johnson	1 Sr	Frede	WYCK	MD			
	ate	31. Date filed (Month, Day, Yea	0 0007	32. Registrar's	Signature	Print) homas	<del></del>	j						
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DHMH 17 Rev 1/2001

		ı	For State Registrar	State of Ma	arylan		artmer <i>rtificat</i>			and Me			e .200	7	37750	
8	Physician /Medical  1. Decedent's Name (First, Middle, Last)  Se Young Ki					Ĺ				2. Date of De Month Nov. 4	ath	3. Time		3. Time of Death 12:57 PM		
	Examin		4a. Facility Name ( <i>If not institution, giv</i> e street and number) 2100 Olney-Sandy Spring Rd				4b. City, Town, or Location of Death Olney					lontgo	County of Death ontgomery			
	Funeral Director			Sex 7.Ag	e (In yrs. 1	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Date of 12/04	th Year <b>19</b>	34 S	Birthpla Count K	ace (State or Foreign (y) Orea	
	n the Maryland r 28a-f show notified at	rector	10a. State MD Montgor  10e. Street and Number	nery	1	y, Town or Lo lney		p Code				10g. C	itizen of What		d. Inside City Limits 1 ☐ Yes 2 📉 No	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	2100 Olney-Sai  11. Marital Status  1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	1 ∐ Yes 2√∑ No			Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2□ No Specify:			cify Yes or No Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: Asian					
Baltimore, Maryland 21215-0036	ed within 72 h ygiene. her than "natu t, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  9 Carpenter								of working  Carpentry  s Name (First, Middle, Maiden Surname)					
	ould be file Mental H larked oth	To Be	17. Father's Name (First, Middle, Last Shin Sun Ki			1			Kur	n Yo	n Kan	a	·			
	es 1 and 2 sh of Health and of Item 27 Is m r other traum		19a. Informant's Name/Relationship ( Pong Ki/Son  20a. Method of Disposition		20b. F	1	5 Gr	eenk	nol	l Ct		ver	or Town, Stary.  Mary.  Location - City	lan	d 21076	
	permit. Pages Department of I Important: If Ite any injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci 21. Signature, 1 Funeral Service Line	<u> </u>	Ga		îTLTî	gd Addres	rtna	ĽDI	FUNER	AL	SERVI	CE,	ring,Md.,P.A.	
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Division or Vital Records, P.O. Box 68760,	icate be executed by physician and physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Libease or injury that initiated events resulting in death) Last	b. Due to (or as  c. Due to (or as	a conseq	uence of):										
	the death certil / the attending ched for use a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)						23d. Date of Month	3d. Date of delivery Month Day Year				
	w requires that been signed by should be deta	by	r art ii. Other significant continuous continuous to the cause of the													
	The law ate has b page 2 si	24a. Was an autopsy performed?   1   Yes 2   No 3   Prob									to con	osy findings available npletion of cause of 2 No				
	ding Physic n. After this ce funeral direc	ation: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending investigation	ER/Outpatie 28b. Time of Injury						()						
	i Effe	27. Manner of Death  1  Natural  28d. Date of Injury  Month, Day Year)  1  Suicide  4  Homicide  28d. Date of Injury  Month, Day Year)  28d. Date of Injury  Month, Day Year)  28d. Date of Injury at Work?  1  Yes 2  No  28d. Describe how injury occur  North  28d. Describe how injury occur  28d. Describe how injury occur  North  28d. Describe how injury occur							ite)							
	o the Hospital ithin 24 hours a b the Funeral I ompletely filled	29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. Certifier 29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo.									due to	the cause(s)				
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	4 Sta	ato-	30. Name and address of person who Byoung Lee MI 31. Date filed (Month, Day, Year)	D 13000	Geo.	rgia	Aven		ilve	er S	pring	, Md	2090	5		
	Regist		NOV 0 7 2	007 King		K de	ast 1	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #1, perMD, g874/12/5/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 12:55 A M Howard Charles Kavanaugh Sr. November 6 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 14 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 72 MD 216-30-2163 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at Westminster 1 ☐ Yes 2X No Director Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21158 1921 Tyrone Road within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc ☐ Yes 2 XNo Yes, Give 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: δ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Iron Worker Union Local #16 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be Joseph Kavanaugh Margaret Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Mary MargaretKavanaugh/wife 1921 Tyrone Road Westminster, MD 21158 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/09/2007 permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Meadow Branch Cemetery Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Pritts The and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician espive acute /Medical Due to (or as a consequence of): Examiner menmoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Examine that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. ed by the a 9☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page perform certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Certification: Division 1 Natural (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0035106 NOV 6, 2007 WJL 6+6

State

Registrar

31. Date filed (Month, Day, Year)

Myung HeeNam, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Myung HeeNam, MD 400 W. 7th Street Frederick, MD 21701

2007

Glown & Sperke

DHMH 17 Rev 1/2001

Registrar

NOV 0 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Items 23, Pt II, 25 per me and Mental Hygiene

Registrar Re 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Lucille Lawrence Lyon 4:00 A M November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 23295 Clam Court Way St. Mary's Clements If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) August 22,1924 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 1 F Hours 83 213-22-1731 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at Maryland St. Mary's Clements Director 1 ☐ Yes 2K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23298 Clam Court Way 20624 IISA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: ģ 3 ₩ Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ned withir.

127 Is marked other than "n.

17 traumatic event. Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill treent of Health and Mental H tant: If Item 27 Is marked oth Be James Dudley Thompson Mary Agnes Lawrence P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Lyon Gardiner / Daughter 23295 Clam Court Way Clements, MD 20624 Department of Health Important: If Item 27 any Injury or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State November 12, 2007 Leonardtown, Maryland 4 □ Donation 5 □ Other (Specify) Charles Memorial Gardens 21. Signature of Funeral Service 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EXTENSIVE MICHISTASCS Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner ENTERNA APPROVED BY MEDICAL EXAMINE the death certificate be executed burial-trar Due to (or as a consequence of): 68760 signed by the attending physician d be detached for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Dav 5 ☐ Other (specify) o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by INTRATROCHANTERIC PRACTUR LOFT hip due to Breast 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cancer with Metastases has page 2 autopsy perfor After this certificate funeral director, pag Vital 1□ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Sother (Specifical Africa) that 1 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital rtifyIng PhysIcIan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signatura 29c. License number and title of certifie 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) NOV 1 3 2007



30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) John W. Roache, M.D.

Registrar

D15027

11/12/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 00:15 a.m. Fredrick Edward Lilley, Sr. November 13, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 XM 2 □ F May 6, 1932 Illinois Director 75 321-26-9108 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director St. Mary's Leonardtown Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 23285 Point Lookout Road 20650 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No à Specify: White 3 ☐ Widowed 4 X Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Firefighter Department of Navy is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Hawf ပ Fredrick Lilley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38440 Mt. Wolf Road, Charlotte Hall, MD 20622 <u>Barbara Bates / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Briosfield-Echols Cr. 11-17-2007 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01206 Kyle S. Simons 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIAC **Physician** /Medical Due to (or as a consequence of): Examiner ISCHEMIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner COROWARY The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No ၉ To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 1) 56096 11-13-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GiLL M.D. RAJBINDER 24035 Three Notch Road, Hollywood, MD 20636 31. Date filed (Month, Day, Year) State NOV 1 4 2007

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 2007 Kirby Nov /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Balkmore NONE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1**X** M 2□ F Director 048-72-2525 26 CONNECTICUT JAN. 14,1981 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director PRINCE GEORGES MD. LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12929 LAUREL BOWIE RD. 20708 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1√ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☑ Never Married 2 Married 2 □ No  $\frac{2001}{2007}$ 1 ☐ Yes 2 📆 No Specify. ģ Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. NAVY **DEFENSE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **KIRBY** LEWIS **DEMETRA** DIXON ဥ Α. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIRBY A. LEWIS/FATHER 53 LINWOOD DR., BLOOMFIELD, CT. 06002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) SAINT BENEDICT CEM. 11-14-07 BLOOMFIELD, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P. A. MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician S'epsis Due (or as a consequence of): disease or condition resulting in death) /Medical Examiner 1 month neutropenia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed leukema acute lymphocytic

Due to (or as a consequence of): attending physician and Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' certificate 2 1 NO Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, To the Hospital o within 24 hours aff To the Funeral D

> State Registrar

E

29b. Signature and title of collifier

MD Frasch egistrar's Signatur

MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parker

22 South Greene Street Bullimore, MD 21201

29c. License number

P21190

29d. Date signed (Month, Day, Year)

Nov 5, 2007

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician November 6, 2007 Lamb 5:15 Frances а R. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arden Courts Assisted Living Montgomery Potamac If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M & F 577-05-9654 Director 91 Dec. 16, 1915 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28a-f show 1 ☐ Yes 2 No ns 23a or 28a-f sh must be notified Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a 11601 Split Rail Court 20852 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Lygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Librarian Public Library 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Paul Roseman Caroline L. King ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jennifer M. Renzi/Daughter 11601 Split Rail Court, Rockville, MD 20852 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Nov. 10, St. John's Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee Francis J. Addes I fast Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 gung. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami as the burial-trar Due to (or as a consequence of): Box 68760, attending physician g Physician/Medical IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 2 No 3 Probably 4 Unknown 1 Tyes Hypertension, Malnutrution, Advanced Dementia, Sick Sinus Syndrome, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Aphasia, Hyperlipidemia autopsy performed? Yes ZANo has page 2 certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Ssisted Living 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P Manner of Death funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending Injury 1 Yes 2 No death. 2 Accident investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 29a. Certifier 1反 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier D53367 November 6, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rajan Shyamsundar, MD 9801 Georgia Avenue, #117, Silver Spring, MD 20902 31. Date filed (Month Day, Year) gistrar's Signature State 2007 Registrar

	8958 am Anthony	Lev	Please Typ	oe or Print i	n Black In and / Depa	delible I	<b>nk. E</b> n f Healti	sure n and	All Copie Mental H	es Are L vaiene	egibl		20.	7 077
			1- For State Registrar			tificate o					Reg. No	21	JU	7 3775
Me	Physici dical Exami		William Antho	ny Lewis						2. Date of D Month Novemb		2007 Year	(	3. Time of Death 1102 hrs
			4a. Facility Name (if not institution 4807 Somerset Road	n, give street and n	umber)		4b. City, To Laurel	own, or Lo	cation of Death			c. County of Prince Ge		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under	1 Year	If Under 24Hrs	. 8. Date of	1		9. Birth	place (State or Foreign
	Director		216-70-8670 Usual Residence of Decedent	1 <sup>X</sup> M 2 F	45	Yrs	Months S.	Days	Hours Min	_		1962	Cour Ma	aryland
	v any		10a. State 10b. County		10c. City,	Town or Locat	tion						T	10d. Inside City Limits
	/land -f shov once.	tor		ce George	e's	Rive	rdale							1 Yes 2 XNo
4	or 28a	Director	10e. Street and Number 4807 Somerse	+ Pond			10f. Zip (		0.7		1	tizen of Wha	t Count	ry?
110714	with the ns 23a		11. Marital Status		cedent Ever in U.	S. 13. Wa	as Deceden	207 It of Hispa	onic Origin? (Sp	pecify Yes or		5A 14. Race -	America	an Indian, Black,
	Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		Armed F	2 X No				Mexican, Puerto			White,	etc.	
	ırs afte ural",	þ	Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give Ye or Dates: cify only highest gra		16a Deceder		No .	specify:	work done	I16h	Specify: W	-	
	72 hou n "nat	Completed	Elementary/Secondary (0-12)		1-4 or 5+)				O NOT use reti		100	Mild of Edsi	11622/111	uusiiy
	5-0036 Led within 7 Hygiene. Lother than the Medica	lduc		2		L	etter						tal	Service
	215- be filed ntal Hyg rked oth	Be C	17. Father's Name (First, Middle, Billie Lewis	Last)					.Mother's Name atricia			,	~ m	
	212 tould b d Ment is mark	ToE	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address		and Number or I					Zip Code)
	MD and 2 shr alth and 2 is raumat		Mark Alan Lewi 20a. Method of Disposition	s/Brother										, MD 20142
	more, Pages 1 a nent of He ant: If ite		1 Burial 2 X Cremation		rom State Me	Place of Dispos prematory or ot Cropoli	ther place)	e or ceme rema	tory		0	. Location - 0	City or T	own, State
	Baltim permit. Pa Departmen Important injury or o		4 Donation 5 Other Sp. 21. Signature of Funeral Service			22 1	Name and A	Address o	f Facility	07				Virginia
	Ba pern Dep Imp		Cincle	w OG	le	IFr	ancis	J. (	Collins ity Blv	Funer	al F Silv	Home In	nc. rino	, MD 20901
	Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause		caused the death.									Approximate Interval Between Onset and
4	:aminer		Immediate Cause (Final disease or condition resulting in death)		gunshot t		head							Death
			Sequentially list conditions,	b.	a consequence o	1).								
		iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence of	f):								
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	executed an and al - transit	- <del>-</del>	X UNPENDED	d.										
	'60, ate be	Medi	IF FEMALE:	23c. If yes,	7,28a-f, po	ermE,g874	4, 12/2	24/07	TT		2	3d. Date of d	leliverv	
	687 certific ading p	ian/I	23b. Was decedent pregnant in the past 12 months?	ne 1 Live		2 Fe	etal death		Ectopic pregna	ancy		Month	Da	y Year
	Box 68760, e death certificate be the attending physical for use as the buri	Physician/Medic	1 Yes 2 No 9 Uni			5 O	ther (Speci	ify)			- 1			
	ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be ex r death extension of the certor: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial.	by Pr	Part II. Other significant condit	ions contributing	to death but not re	esulting in the	underlying (	cause giv	en in Part I.					ne cause of death?
	duires quires uld be				<del></del>					11 24a. W		✓ No 3	LUSAN	
	24a. Was an autopsy prior to co death?  1 ✓ Yes 2 No 1 ✓ Yes									opsy findings available impletion of cause of				
	Re The tificate or, pag		25. Was case referred to medica				2	6 Place o	f Death (Check	1 <b>✓</b> Ye	s 2		✓ Yes	2 No
	of Vital Records, ng Physician: The law require this certificate has been si neral director, page 2 should t	o Be	examiner?	Hospital: 1	Inpatient 2	ER/Outpatient		10	hor.	ng Home 5	Resid	dence 6 🗸	Other:	Scene
	n of ing Ph After t funeral	n: T	27. Manner of Death		e of Injury h, Day,Year)	28b. Time of	Injury 2		at Work?	l .		njury occurre	d	
	Sior Attend death ector: by the	catic		stigation Fnd 1.	1/19/2007	Fnd 10:			s 2X No			ot self		
	Division tal or Attendir as after death al Director: Alled in by the fu	ertification:		d not be 28e. Pla mined (Specify	ce of Injury - At he residen		et, factory,	office buil	lding, etc.					al Route Number, City rdale, MD
	Division To the Hospital or Attendi within 24 hours after death To the Funeral Director:	ပ	20a Certifier	nysician: To the be	st of my knowled	ge, death occu	rred at the	time, date	and place, and					
	To the within compte	Medical	one) 2 Medical Exam	and manner		nd/or investiga				at the time, da				
	5	Σ	29b. Signature and title of certifie	11 /	1			O.C.M.				I. Date signe ovember 2	•	
			30. Name and address of person	who completed car	ise of death (Item	(23a)		J.U.IVI			- I'vi	740111DEL 2	-0, 20	
			Jack Titus MD. Dep	uty Chief Medi	cal Examine	r 111 Pe	nn Stree	t, Baltin	nore, MD 2	1201				
	SI Regis	tate trar	31. Date filed (Month, Day, Year)	L 2007 32.	gistrar's Signatu	8 40								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08592 State of Maryland / Department of Health and Mental Hygiene Robert Etchison Luthy Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day November 4, 2007 Physician/ 2215 hrs Etchison Luthy Robert Mediani Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Dorchester Cambridge 2735 Dorchester Square Mall 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min Aug. 29, 1983 MD 24 Director 214-04-6735 Yrs 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County any Yes 2 X No Cambridge , or items 23a or 28a-f show r must be notified at once. Dorchester Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21613 4529 Maple Dam Road 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc Armed Forces? 2 Married 1 X Never Married white XYes Yes 2X No specify: Specify If Yes, Give Year 2002-06 4 Divorced Widowed Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after
Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) military Marine 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Diann Etchison Be Mark J. Luthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 4529 Maple Dam Road, Cambridge, MD father Mark J. Luthy 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Cremation 3 Removal from State 1 X Burial 2 11/8/07 Cambridge, MD Bucktown Churchyard Donation 5 Other Specify: Thomas Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. Death **Tedica** a. Contact Gunshot Wound of Head Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical AMENDED UNPENDED attending physician or use as the burial The law requires that the death certificate be 23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death detached for use as past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. Yes 2 No 3 Probably 4 Unknown ğ 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy performed? death? has ✓ Yes 2 No 1 Yes certificate h 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Other<sub>4</sub> Be Residence 6 Other: Scene Hospital: 1 Nursing Home 5 DOA ER/Outpatient 3 Inpatient No 1 V Yes 2 2 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death After Subject shot self Certification: FOUND: Yes 2 V No Natural Pending Director: A hours after death. Nov 4, 2007 2206 hrs Investigation 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 2735 Dorcester Square Mall, Cambridge, MD determined (Specify) Parking Lot To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Wilder Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal and manner stated 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 5, 2007 O.C.M.E.

State 31. Date filed (Month, Day, Registrar

lu a

Melissa Brassell, MD

Assistant Medical Examiner

istrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

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DOME

30. Name and address of person who completed cause of death (Item 23a)

2007

			For State		State of Ma	aryland		rtment of F tificate of	leaith and N Death		_		
E			Registrar     Decedent's Name (First, III)	Middle, Last)				inoute or	Death	2. Date of De		2001	3. Time of Death
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	Examin		4a. Facility Name (If not insti		or '	r			r Location of Death		40	County of Deat	
47	Funeval		FREDERICK ME: 5. Social Security Number	6. Sex		e (In yrs. las	st birthday)	FREDERI If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	FREDERI 9. Birti	nplace (State or Foreign
HS,	Funeral Director	g i	405-60-7680		M 2 F	61	Yrs.	Months Days	Hours Min.	April	y, Year 18,	1946 <sup>Co</sup>	KY
	land		Usual Residence of Deceder 10a. State 10b. Co			10c. City,	Town or Lo	cation					10d. Inside City Limits
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	ith the	Director	10e. Street and Number					10f. Zip Code			10g. Ci	itizen of What Co	untry?
	s 23a nust t		1907 Belfor		2. Was Decedent	Ever in II C	10.1	2170:		and Variable		USA 14. Race - Amei	doen Indian
-	fter de r Item iner r	Funeral	11. Marital Status 1 ☐ Never Married 2X		Armed Forces? 1∑ Yes 2 ☐ If Yes, Give		, 13. 1		lispanic Ongin? (Sp an, Mexican, Puert	o Rican, etc.)	-	Black, White	e, etc.
215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divo	orced	If Yes, Give Year or Dates:	1970		I∐Yes 2. <b>Xi</b> No	Specify:			Specify:	White
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<u>\S</u>	2 should be filed and Mental Hygi is marked other aumatic event, t	ပ္	Hansel Luca		- Owint		401 14:22			Walden			
Baltimore, Maryland 21	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Rela Janice Lucas/		e. Print)		190. Mallin	7 Belford	and Number or Ru l Ct Fre	derick,	MD	21702	(ip Code)
ore,	es 1 a of Hez		20a. Method of Disposition 1 ☐ Burial 2  Crema	tion 2 DB	amount from State	20b. Pla	ce of Dispo	sition (Name of natory or other plac	ce) 11/0	6/2007	20c. L	ocation - City or	Town, State
Ĕ	. Pages tment of I tant: If Its		4 Donation 5 ☐ Oth	ner ( <i>Specify</i> )	1	Carı	coll (	Cremation	, Inc		Ha	mpstead,	MD
Ball	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Se	rvice License	0	_			ered Hom			et, P.A. ster, MD	21157
lè	1 10		23a. Parl 1. Enter the disease brock, or heart failure.	se, or omplic	cations that caused e cause on each li	the death.	Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician	8 1	Immediate Cause (Final disease or condition resulting in death)	a		He	art	Dise	ase			XI	Onset and Death
i i	/Medical Examiner		rooding in dedaily		Due to (or as	a conseque	nce of):	Lastes	1				
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л. О	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Physician/M	1  Yes 2  No 9  Unknown		4□Pregnant at 9□Unknown	t time of dea	ith 5	Other (specify)				World	Day Tour
	w requires that the dibeen signed by the should be detached	by Ph	Part II. Other significant co	nditions con	tributing to death b	ut not resulti	ing in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco	use contribute to	the cause of death?
Vital Records,	require een siç nould b									10	Yes 2	Pro 3d Pro	obably 4 Unknown
Š V	has by	Completed								24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of
<u>ra</u>	sician: The law certificate has b irector, page 2 s		25. Was case referred to me	edical					26. Place of Dea	1□ Yes	2 2 N		2 No
	nysicia nis cer direct	To Be	examiner? 1 ☐ Yes 2 No	1	ospital: 1 🔲 Inpatie	ent 2.	R/Outpatien	t 3 DOA Oth	or.			6 ☐Other (Spec	cify)
Division or	ing Pt			ending	28a. Date of Inju (Month, Da	y Yea <i>r</i> )	8b. Time of Injury	Wor		28d. Describe I	now inju	ury occurred	
ISIC	death ctor: ,	ficat	3 ☐ Suicide 6 ☐ C	vestigation ould not be etermined	28e. Place of inju	ury - At hom	e, farm, str	M 1 □	Yes 2 □No	28f. Location (S	Street a	nd Number or Ru	ral Route Number,
2	s after al Dire	Certification:	4 ☐ Homicide	eterriirieg	building, et	c. (Specify)				City or Tov	vn, Stat	te)	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I.	Medical (	29a. Certifier 1 Cer (Check only one) 2 Med	tifying Phys dical Examir	ician: To the best er: On the basis o	f examinatio	edge, death on and/or in	occurred at the tir	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s	s) and manner as nd place, and due	stated. to the cause(s)
	Fo the within 2 Fo the comple	Mec	29b. Signature and title of ce	ertifier	and manner sta	ateu. 		29c. Licens	e number		29d. Da	ate signed (Montl	n, Day, Year)
	XI X		· OWN	A	Emeraena	. Py	MS:	HOM CO	40539			novemb	xr 9 200
٨	15XIVE		30. Name and address of pe John Moleswor		mpleted cause of d	eath otem 2	3a) (Type, Stree	Print)	erick, MD				7
	Sta	te	31. Date filed (Month, Day,	Year)	32. Registr	ar's Signatu	re		•				
	Registr	ar	NO.	V 05	2007	ANES	15.	Sparke					

KP

State Registrar

29b. Signature and title of certifier

0°8 2007

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

FRED YEO, M.D., NATIONAL NAVAL MEDICAL CENTER, 8901 WISCONSIN AVENUE, BETHESDA, MD 31. Date filed (Month, Day, 20889

29c. License number

D0061109

29d. Date signed (Month, Dey, Year)

NOVEMBER 6, 2007

			1 - For State Registrar	State of M		partment of ertificate o		and Mental Hy	giene Reg. N2 0 0	7 37761
	Physic /Medi		1. Decedent's Name (First, Middle,	MOORE				2. Date of De. Month	Day, Y	3. Time of Death
	Examir			Drant	HOSPIM	4b. City, Town	A RAZ	K		COMERY
	Funeral Director		578 78 9008	6. Sex 7. Ag	e (In yrs. last birthda 50 Yrs	Months Day		Min. 8. Date of Bin (Month, Da MAY 27	y, Year)	O. Birthplace (State or Foreign Country) ORTH CAROLINA
	aryland	J.	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or				<del> </del>	10d. Inside City Limits 1 ☐ Yes ※※ No
	ith the Marylar or 28a-f ahow se notified at	Funeral Director	MD PRINCI	E GEORGES	ADELPHI	10f. Zip Code	)		10g. Citizen of Wh	
	th wil	aiD	10505 EDGEMONT	DRIVE		20	0783		UNITED	STATES
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Itama 23a or 28a-f ahow or other traumatic avent, the Medical Examinar must be notified at	by	11. Marital Status  1 Never Married 2 Marrie 3 Widowed XXDivorced	12. Was Decedent Armed Forces? ad   Yes XX   If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of If Yes, specify Cu		gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. BLACK
21215-0	within 72 hours iene. 'then "neturel", he wedical Ex.	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5	(G 5+)	cedent's Usual Occive kind of work don b. DO NOT use reti	ne during most red)	t of working	16b. Kind of Busin	ness/industry
nd 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic avant, the M	Be	17. Father's Name (First, Middle, L		30	HOOL TEAC	1	r's Name (First, Middle,		
<u>y</u> la	should that and Ment	2	FRED MOORE, JR.					E PALMER		
Maryland	d 2 sho th and 7 Is mu traum	1	19a. Informant's Name/Relationsh VELMA LAW / SIS	ip (Type, Print) STER		ailing Address <i>(Str</i> e 5 EDGEMON		r or Rural Route Numbe	er, City or Town, St L,MD 207	
Baltimore,	Pages 1 and 3 lent of Health nt: If Item 27 iry or other true		20a. Method of Disposition  XXBurial 2 □ Cremation  4 □ Donation 5 □ Other (Sp	3 □Removal from State	20b. Place of Discemetery, of	sposition (Name of rematory or other p	lace)	Date 11/14/2007	20c. Location - Ci	
Balti	permit. Pag Department Importent: I any injury o		21. Signature of Foneral Service L	cushU			ress of Facility S FUN	YERAL HOME		ND, INC.
0	Physician		23a. Part. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	nly one cause on each li	the death. Do not ne.	1			rrest,	Approximate Interval Between Onset and Death
Mr.	/Medical Examiner		resulting in death)		a consequence of):					
8760,	The law requires that the death certificate be executed the has been signed by the ettending physician and bage 2 should be detached for use as the burial-transit.	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	a consequence of): a consequence of):					
9	tificate g phys as the	edic		u.						
P.O. Box	that the death certific: led by the ettending ph detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death	3 □Ectopic pregnar 5 □ Other (specify)	псу		23d. Date of Month	
	w requires that been signed b should be deta		Part II. Other significant condition	s contributing to death b	ut not resulting in the	underlying cause	given in Part I.			ute to the cause of death?
of Vital Records,		Completed by		`					osy price dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 \( \subseteq \) No
Vit.	Physician: Th this certificate ral director, pag	Be	25. Was case referred edical examiner?	Hospital:		10	)thor	of Death (Check only of		
of	Phys	. To	1 Yes 2 No	28a. Date of Inju	ry 28b. Time	IBIN 3L DOA	4 🗀 NUI	rsing Home 5 Resi	dence 6 Other	
ion	Attending Physician: r death. ector: After this certific by the funeral director.	ation	1 Accident 5 Pending		<i>y Year)</i> Injur		lork? ∐Yes 2.∐h	No		
Division	or At fter o direct	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		ury - At home, farm, c. (Specify)	street, factory, offic	е	28f. Location (: City or To		or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the best xaminer. On the basis o and manner st	examination and/or	eath occurred at the investigation, in my	time, date and y opinion, deat	d place, and due to the th occurred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To th vithir To th comp	M	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (	(Month, Day, Year)
	100		- who	CM Wi	•	35	427		11-02	-2007
2_	2		Dames Tinda	no completed cause of d	100 Ca	well her	TAKM	A Prove	MD.	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 2007	32. Registr	ar's Signature			50		

			For	State	of Marylar		artment of H		Mental Hyg	jiene	_	
			State Registrar	. ( 1)		Cei	rtificate of	Death	2. Date of Dea	eg. No.2	007	37762
	Physicia	an	1. Decedent's Name (First, Middle						Month	Day	Year	3. Time of Death
	/Medic		Ruby Pe		Morgan		4b. City. Town. o	r Location of Death	Novembe		, 2007 ounty of Death	2:25 a.m.
}	Examin	er	St. Mary's Nu				,	nardtown		S	t. Marv	1 0
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	)		lace (State or Foreign
	Director		219-12-4093	1 □ M 2 🗓 F	85	Yrs.	World Days	TIOUIS WIIII.	9-23-19		Mary	**
	pu v		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation				1	0d. Inside City Limits
	lanyla short ed at	5		_								1 ☐ Yes 2 🔯 No
	the N 28a-1 notifi	Director	Maryland St.  10e. Street and Number	Mary's		H	10f. Zip Code			10g. Citize	n of What Coun	itry?
	3a or	ā	24399 Morgan Ro	na đ				20636		Unit	ed Stat	A 5
	ms 2	Funeral	11. Marital Status		cedent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-		I. Race - Americ Black, White,	an Indian,
0	after or ite mine		1 Never Married 2 Man	ried 1 ☐ Yes	2 No		1 □ Yes 27 No	Specify:	or moun, oron,			hite
0030	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medisal Examiner must be notified at	d by	3 Widowed 4 □ Divorced	Year or	Dates:						of Business/Inc	
Ď	"nat	Completed	(Specify only highe			1 (Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	IOD. KING	I OI Business/inc	dustry
7	withi iene. than the M	E C	Elementary/Secondary (0-12)	College	(1-4or 5+)	Cafet	eria_Mana	ager		Pub	lic Sch	ools
ם פ	Hyginal Hygina	BeC	17. Father's Name (First, Middle,	Last)		1 001200	0110	18. Mother's Nam	ne (First, Middle,			
land	Ald be Aenta rked ric ev	P P	William Frank	clin Pegg				Drucy	Gatton			
Mary	and N s ma		19a. Informant's Name/Relations			19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or 1	Town, State, Zip	Code)
a,` ≥	and and n 27		Carol L. Nelson	ı/ Daught			Hollywoo	od Road,	Hollywoo		aryland	
0	ges 1 If itel or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from	m State	cemetery, cre	osition (Name of matory or other place	1			•	
aitimo	tt. Pa rtmen rtant:		4 □ Donation 5 □ Other (5		Cha	arles M	lemorial (	Gdn. 11-1	9-2007 I	Leona	rdtown,	Maryland_
g Q	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	X.	2		2. Name and Addre					
7	1		Edward N. Brine 23a. Part1. Enter the disease, o shock, or heart failure. List	field J	r MOO( t caused the dea	th. Do not en	ter the mode of dying	ng, such as cardiac	or respiratory ar	rest,	n, MD Z	0650-0279 Approximate Interval Between
	Physician		Immediate Cause (Final	only one cause or	each line.	15-1	explic	CARL	ed an e	(	Des	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due t	o (or as a conse	quence of):	exolic	· Medic	FUASUL	CANC	Hospi	m yes
	Examiner	П	Sequentially list conditions,	b								
NΞ	p #	iner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due t	o (or as a conse	quanes of):						
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a conse	quence of).			·	-		
8/00,	eath certificate be executed attending physician and for use as the burial-transit				- (	,						
200	ficate physis the	edical		d								
ŏ	death certificate e attending physi d for use as the I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregre birth 2  Fe		⊒Ectopic pregnanc	.,		23	Bd. Date of delive	*
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specify)	у			Month	Day Year
J.	w requires that the de been signed by the should be detached	h y	9 Unknowh			100 1 10	4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	on to One t	One Did to	ahaaaa ua	o contributo to t	he cause of death?
Š,	requires that een signed b nould be deta	þ	Part II. Other significant condit	ons contributing to	death but not re	suiting in the t	indenying cause giv	ven in Part I.	1 🗆 1			bably 4 □Unknown
Hecords	requi	Completed										
ě	e law has b je 2 st	mple							24a. Was autop perfo		prior to co death?	opsy findings available impletion of cause of
	n: The ficate ha r, page		05.11	-1				00 84 (8	1□ Yes	2 No		2 No
VItal	Physician: The law this certificate has be ral director, page 2 s	o Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☒ No	Hospital*	Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	ner: 4X Nursing H	ith <i>(Check only o</i>		Other (Speci	f <sub>V</sub> )
Ö	iding Phys h. After this funeral dir		27. Manner of Death	28a. Da	te of Injury onth, Day Year)	28b. Time of			28d. Describe I			<i></i>
0	nding ath. r: Aft	atio	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng ("" igation	onin, Day Tear)	Injury		Yes 2 □ No				
UIVISION	r Atte er de: irecto	Certification:	3 Suicide 6 Could 4 Homicide deterr	ninod 28e. Pla	ce of injury - At lilding, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (S City or Tov	Street and vn, State)	Number or Run	al Route Number,
5	ital o irs aft ral Di lled in	Se							l l l l l l l l l l l l l l l l l l l			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	ledical		ng Physician: To t I Examiner: On the								
	othe ithin ( othe omple	Mec	29b. Signature and title of certific	^	arrier stated.		29c. Licens	se number		29d. Date	signed (Month,	Day, Year)
)	F 3 F ŏ		· MI	160 1	442m	1	71	4285	_	11-	16-	07
•			30. Name and address of persor	who completed ca	use of death (Ite	em 23a) (Type	Print)		1		E and	
			William D. Boy	d II, M.I	2536	5 Poin	t Lookout	Road, L	eonardto	wn, l	Maryland	1 20605
	Sta		31. Date filed (Month, Day, Year NOV 1 6 230)	) 32	. Registrar's Sigi	nature						
	Regist	rar	LOO	All Belline	BA	Back I						

		Tes Zano
25. Was case referred to medical	26. Pla	ce of Death (Check only one)
examiner? 1 ☐ Yes 25 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ N	Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1X Certifying Ph	nysician: To the best of my knowledge, death occurred at the time, date	and place, and due to the cause(s) and manner as stated.

1 🔀 Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day Year)	injury M	1 ☐ Yes	2 🗆 No	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)						e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)

(Check only one)  2 Medical Examiner: On the basis of examination and/or investigence and manner stated.	gation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
29b. Signature and title of certifier  Melclin E. Murden, M.P.	29c. License number 00059223	29d. Date signed (Month, Day, Year) November 8, 2007

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

215 North Street, Svite C, Elkton, MD 21921 Melchor E. Madarana M.D 32. Registrar's Signature

State

Medical

13

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		316	ile Oi	iviai yia					Death		eniai m	Reg. 1				
Physicia /Medic		1. Decedent's Name (First GLENDA	st, Middle,	Last) FAYE	MA	AXWELI							2. Date of D Month NOVEMB	eath	20	07 07 <sup>ar</sup>	-	of <b>p</b> eath 4 50 Ам
Examin		4a. Facility Name (If not in PRINCE GEO								, Town, oi	LY Location	of Death			4c. County		RGE'	S
Funeral Director		5. Social Security Numbe 241-72-5464		3. Sex 1 ☐ M 2		. Age <i>(In yi</i>			If Unde Months	Days	If Under Hours	Min.	8. Date of B JULY	Sirth 3, Yea	947			te or Foreign OLINA
Maryland -f show lied at	tor		. County	GEOR	GE'S	10c. 0	City, Town			GHTS						11		City Limits
th the or 28a	)irec	10e. Street and Number					· · · · · · · · · · · · · · · · · · ·		10f. Zi	p Code				10g. (	Citizen of \	What Coun	try?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral Director	809 CEDAR  11. Marital Status  1 Never Married  3 Widowed 4	2 <b>X</b> Marrie	12. Wa Arı d 1 [		ent Ever in es? : XNo	U.S.		as Dece Yes, sp	0743 edent of H ecify Cuba 2X No	ispanic Or an, Mexica Specify		ecify Yes or N Rican, etc.)			ee - America ck, White, o		
in 72 ho n "natur A dical E	Completed	(Specify on	nly highest			( F.)	16a. [	Decede (Give ki life. D(	ent's Usi ind of w O NOT i	ual Occup ork done o use retired	ation during mo.	st of worki	ng	16b.	. Kind of B	usiness/Ind	fustry	
ygiene ger thau	Som	Elementary/Secondary	7 (0-12)		llege (1-4 4 YR		PSY	CHI	ART	RY NU	JRSE				GOVE	RNMEN'	Γ	
d be file	Be	17. Father's Name (First, ROSCOE SMI		ast)								ner's Name LULA	(First, Middl SAND)		len Surnan	ne)		
should and Me s mark umatic	To	19a. Informant's Name/F	Relationshi	o (Type. Pri	int)		19b.	Mailing	Addres	s (Street			A Route Num		y or Town,	State, Zip	Code)	
and 2 lealth a m 27 is				LL/DA	UGHT	ER	809	CE	DAR	HEIG	GHTS							20743
Pages 1 nent of H nt: If ite iry or otl		20a. Method of Disposition  1 Burial 2 Cre 4 Donation 5 D	emation 3		al from S	ate	. Place of I cemetery	, crema	atory or	otner plac		11/9/	<sup>2</sup> 2007		Location -			
permit. Departm Importa any inju		21. Signature of Funeral	Service Li	censee ,	alı						ss of Facil		LANDO				AL HO 2078	
Physician		23a. Part1. Enter the disshock, or heart failt Immediate Cause (Final disease or condition	ease, or c	omplication	s that car se on ear	used the de th line. SOPHA		ot enter	r the mo	de of dyin							Approxir Interval	nate
/Medical Examiner		resulting in death)	- 1			ras a cons ERITO			CIN	OMA								
ted sit	Examiner	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ns, late	b		rasa cons ESPIR			ILU	RE								
rificate be executed g physician and as the burial-transit	fedical Exar	that initiated events resulting in death) Last		c		r as a cons EPSIS		f):										
ath cer ttendir or use	Physician/Med	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 □ Yes 2 □ No 9 □ Unknown		1 <u>[</u> 4 <u>[</u>	Live bir	ome pf preg th 2 Fe nt at time o	etal death		Ectopic   Other (s	oregnancy	′		-		1	te of delive	ry Day	Year
uires that the de signed by the a ld be detached f	by	Part II. Other significant	condition	s contributi	ng to dea	th but not r	esulting in	the und	derlying	cause give	en in Part	l.			o use cont			of death?
aw requir as been si 2 should l	Completed	RENAL :	FAILU	RE									24a. Wa	s an	24b.	Were auto	psy findin	gs available
n: The lav ficate has nr, page 2 s		CONGES'		HEART	FAI	LURE					20 71		per 1□ Yes		?	death?	No No	of cause of
nysician: nis certific director,	To Be	examiner?  1 Yes 2 No	medicai	Hospita	l: 1 🏡 Inj	patient 2	☐ ER/Outp	patient	3 🗆 D	OA Oth	er:		n <i>(Check only</i> me 5 □ Re		- 6 □Oth	ner (Specifi	/)	
nding Phys th. :: After this e funeral dii		27. Manner of Death 1 X Natural 5 □ 2  Accident	☐ Pending investiga		. Date of		28b. Ti		М	28c. Injur Worl	y at	12	28d. Describe					
ai or Atters after dea	Certification:		Could no determin		. Place o	f injury - At g, etc. <i>(Sp</i> e	home, farr	m, stree	et, facto	ry, office		2	28f. Location City or T			per or Rura	I Route N	lumber,
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C			xaminer: O	n the bas								and due to the					se(s)
To th withir To th comp	Me	29b. Signature and title of	of certifier	_					1 .	)58 /	-				Date signe	d (Month,		r)
(2)		30. Name and address o	f person w	ho complete	d cause	of death (It	em 23a) (1	уре, Р		1			3 6		11 0			

State Registrar

31. Date filed (Month, Day, Year) NOV 0 9 2007

3001 HOSPITAL
32. Registrar's Signature

Cheverly MD 20785

			1- For State of Maryland / Department of State of Maryland / Department / Dep	artment of Health an		ene 2007 37765
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Howard G. Martin C.  4a. Facility Name (If not institution, give street and number)  32810 Longridge Rd.	4b. City, Town, or Location of C Parsonsburg	2. Date of Death Month	
	Funeral Director		5. Social Security Number 212-10-5573 6. Sex 12 M 2 F 90 Yrs.	If Under 1 Year   If Under 24	Hrs. 8. Date of Birth (Month, Day, 8/20/19)	***************************************
	Maryland I-f show	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Low           MD         Wicomico         Parsons			10d. Inside City Limits 1 ☐ Yes 2 🏋 No
	with the 3e or 28s	I Direc	10e. Street and Number 32810 Longridge Rd.	101. Zip Code 21849	10	g. Citizen of What Country?  USA
036	be filed within 72 hours after deeth with the Maryland at thygiene. All the Wedical Evaniner must be notified at event, the Medical Evaniner must be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin 1 Yes, specify Cuban, Mexican, F	1? (Specify Yes or No- Querto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	i within 72 ho iene. r than "netur	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12 Super	dent's Usual Occupation kind of work done during most o DO NOT use retired)	f working	6b. Kind of Business/Industry  Machine Shop
yland		To Be C	Howard Martin	Mary	Name (First, Middle, M Y Ägnes Krai	aiden Sumame) JS
, Mar	ulth a			ng Address (Street and Number of X 339, Bishopy		
nore	Peges 1 and the total that the title of the try or other		1   Burial 2 & Cremation 3   Bemoval from State	sition (Name of natory or other place)		oc. Location - City or Town, State Frankford, DE
Baltimore,	permit. Peges 1 Department of H Important: If ite eny injury or ott		21. Signature of Funeral Service Licensee	Name and Address of Facility  08-William St.	The Burbage	e Funeral Home
/pn,	Physician / Medical Examiner prize p	ilcal Examiner	23a Part 1. Enter the dispedse or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	D) seese		st, Approximate Interval Between Onset and Death
O. BOX 68	res that the death certitica igned by the attending ph be detached for use as th	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?  s 2 No 3 Probably 4 Unknown
аі жесога	The law ate has b page 2 si	Completed			7	prior to completion of cause of death?
or vital	S D	To Be	25. Was case referred to medical examined?  1   Yes   2   No	nt 3□ DOA Other: 4□ Nurs		nce 6 Other (Specify)
UNISION	tending death. tor: After the fune	Certification:	27. Manner of Death    1	Work? M 1 □ Yes 2 □ No	28f. Location (Str	eet and Number or Rural Route Number,
2	To the Hospital or All within 24 hours after or To the Funeral Direction policies of the Funeral Direction places of the Funeral Direction of the		4 Homicide building, etc. (Specify)  29a. Certifier 1 Destritiving Physician: To the best of my knowledge, deat	h occurred at the time, date and	City or Town.	use(s) and manner as stated.
	the Ho	Medical	(Check only one)  2 Medical Examinar: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death  29c. License number		te and place, and due to the cause(s)  Id. Date signed (Month, Day, Year)
	≓ ≯ ∺ 8		Co Oa Cle uns	0262	.78	11-8-07
3.7	30		30. Name and address of person who completed cadse of death (Item 23a) (Type,	Print)	1733 Sal.	54, MD 21802
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Angelle 1		<i>J'</i>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5, 2007 Nellie M. Moore November /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 401 Champlain Road Cecil North East Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months 1 □ M 2 🗓 F Director 420-60-4354 61 June 24,1946 Alabama Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Ceci1 North East 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21901 401 Champlain Road United States Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 Never Married 20 Married 1 ☐ Yes 21 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Human\_Resources</u> U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jimmy Hall Virginia Mewhorter P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Moore / Husband 401 Champlain Road, North East, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November permit. Pages Department of Important: If it any Injury or or 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BrassellCemetery 13, 2007 Montgomery, Alabama 21. Signature of Pun ral Ser 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Completed by Physician/Medical attending p for use as IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 2 □ No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2 NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2[TI No 2 ER/Outpatient 3 DOA P 27. Mannal of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature and

3

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BZ | Riversial and State | Registrar's Signature | Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Lee 7, 4:15 P Motter 2007 Patricia November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 13509 Good Intent Road Union Bridge Frederick If Under 1 Year Months Days Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Hours 1 □ M 2**X** F Director 59 Oct. 10, 1948 Maryland 215-48-5209 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐Yes 2☐No Directo Frederick Maryland Union Bridge 10g, Citizen of What Country? 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 13509 Good Intent Road 21791 United States Funera Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Pickett Mary Conway ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13509 Good Intent Rd., Union Bridge, MD 21791 Samuel Motter / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Department of H Important; If ite any Injury or ot 11/9/2007 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, MD 21702 Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical SS attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 □ Yes 2 🖼 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 140 24a. Was an page 2 s autopsy performed? /es 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident rector: by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) on 24 hours.
the Funeral Directory filled in by determined 4 Homicide 1 🕜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29b. Signature a

30. Name and Iddress of person will

NOV

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

within 2

29c. License number

autarstract Wastminster, MD 21157

29d. Date signed (Month, Day, Year)

and manner stated.

2007

07-08634 Rich

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Metzger		St	ate of M	arylan	d / Depai	rtment of	Health	and	Menta	l Hygi	iene		20	07	3.	776	
	D.	For State Amende	d#10c	per	ен есе	ificate of	Death			T <sub>0</sub>	Re Date of Deat	g. No.	20		e of Death		
Physician		. Decedent's Name (First, Midd	e,Last)								Month November	Day	Year 7		40 h <b>r</b> s		
Marimal Examin	er F	Richard Larue Na. Facility Name (if not institution	<u>letzge</u> n give street	r and num	ber)	4	b. City, To	wn, or Lo	cation of E		VOVEINDE		ounty of Dea	th			
A	4	University Hospital	in, givo sa soc	and man	,		Baltimo	ore									
Funeral	. 5	. Social Security Number	6. Sex	7	. Age (In yrs. Ia	st birthday)	If Under		If Under 2		3. Date of Bir	h(MM/DD	/YYYY) 9. B	irthplace	(State or	Lvania	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	B	Harold Edmund 19a. Informant's Name/Relation	Metzg	er		10h Mailin	a Address	(Street	and Numb	Mae oer or Ru	Baker ral Route Nu	r Imber, City or Town, State, Zip Code)					
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Medical		failure. List only one cause Immediate Cause (Final disease	e on each iii	d Injurie					_	_				$\rightarrow$	Deat	n .	
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Division spiral or Attendin hours after death nneral Director: /	Certification:	d d	4 Homicide determined (Specify) Single Family 13109 Old National Pike, Mt. Alfy, MD														
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			For State Of Registrar	naryland / D	Certificate				g. No. 2	007	37769
	Bloodel		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medic	-	Mary T. Nelson					Nov.	7	2007	6:35 A M
	Examin	er	4a. Facility Name (If not institution, give street and number	r)			ocation of Death			nty of Death	
			Lorien Life Center	N = 2 (1 = 1 = 2   1 =			Airy If Under 24 Hrs.	D. D. L. L. Dish	J	Carrol	
	Funeral Director		5. Social Security Number 6. Sex 1	Age (In yrs. last birth		Days	Hours Min.	8. Date of Birth (Month, Day, March 5	Year) 1912	2 Mas	place (State or Foreign intry) sachusetts
	wc m		10a. State 10b. County	10c. City, Town	or Location						10d. Inside City Limits
	Mary -i •h fied	tor	Maryland Frederick		Mt. Ai:	rv					1 ☐ Yes 2 🖾 No
	r 28a	Director	10e. Street and Number		10f. Zip Ci			10	g. Citizen	of What Cou	untry?
	death with the Maryland ms 23s or 28s-f ehow rmust be notified at		4390 Moleton Drive				21771		Uni	ted Si	tates
	dea me	Funerai	11. Marital Status 12. Was Decede Armed Force		13. Was Deceder	nt of His v Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White	
Maryland 21215-0036	be filed within 72 hours after death with the Marylar ital Hygiene.  Ind Hygiene.  Independent them "natural", or fleme 23a or 28a-f show event, the Madical Examinar must be notified.	by	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Date:		1□ Yes 2₺						White
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<u></u>	should be nd Mental marked imatic ev	F	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (S	Street ar				wn, State, Z	ip Code)
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Baltimore,	permit. Peges 1 and 2 should by Department of Health and Menta Important: If Item 27 Ie marked eny Injury or other treumatic especies.		21. Signature of Euperal Service Licensee		22. Name and		of Facility St	auffer	Funer	al Hor	nes, P.A.
ь	807.9									Mary	Land 21771
			23a. Part1. Enter the disease or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do no line.	ot enter the mode of	of dying,	such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
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	/Medical Examiner		Due to (or a	as a consequence of	f):					1	
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JIVISION OF	tending Physician: The leath. for: After this certificate ha the funeral director, page	ion:	27. Manner of Death 1)⊠Natural 5 □ Pending 28a. Date of h (Month, h	njury 28b. Ti Day Year) In		Work		28d. Describe ho	w injury oc	curred	
<u>s</u>	death death stor;	Icat	2 Accident investigation 3 Suicide 6 Could not be	Injury - At home, fare	M street factors of		es 2 No	28f Location (St	reat and Ni	imher or Ru	ral Route Number,
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	Sta Registr		31. Date filed (Month, Day, Year) 32. Red	strar's Signature	Sporte	- 06	N N'	-10	k P		,,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 4.45P M Arthur James O'Mara, Jr. 7 200 November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Renaissance Gardens at Riderwood Village Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 28, 1920 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F New Jersey 87 721-01-8418 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show be notified at 10b. County 1 ☐ Yes 2 No Maryland Prince George's Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 United States 3160 Gracefield Road, #1209 "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married WWII White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4or 5±) Elementary/Secondary (0-12) Consulting Civil Engineer permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur James O'Mara, Sr. Esther Yeoman 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 3160 Gracefield Rd.,#1209 Silver Spring, Md. 20904 19a. Informant's Name/Relationship (Type. Print)
Lois J. O'Mara -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 11/8/2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 0 21. Signature of Funeral Service Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** dau resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit certificate be executed Due to (or as a co Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ate has been signed by the atter page 2 should be detached for a Month Day Year in the past 12 months? 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2- No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed certificate 1□ Yes 2□No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Lover 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,3110 GRACEFIELD ROAD, SILVERSPRING, MD 20901 LOVEEN J. PUTHUMANA

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2007

ORIGINAL

32. Angistrar's Signature

		1 - For State Registrar		Marylar				ealth a Death	and M		eg. 26.		3	7771
Physicia /Medic		1. Decedent's Name (First, Middle Edith Marie 0								2. Date of Dea Month Novembe	<sup>th</sup> ⊇r I	2, 200	<b>5</b> 7	3. Time of Death 09:15 A M
Examine	4	4a. Facility Name (If not institution Coffman's Nurs	-	oer)		H	ager	Location o			4c.	County of D Washi:	ngto	
Funeral Director		5. Social Security Number 235-58-0330 Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 ဩ F	Age (In yrs.	/ast birthday) Yrs.	If Unde Months	Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day June 2,	Year) 19	12 V	Birthplac Country Vest	ce (State or Foreign Virginia
72 hours after death with the Maryland natural', or itema 23a or 28a-f show ateal Examinar must be notified at	Director	10a. State 10b. County	brier	10c. Ci	ty, Town or Lo	wood	p Code			1	10g. Citi	zen of What		I. Inside City Limits 1 ☑ Yes 2 ☐ No
h wit		175 Home Drive					2598	L				USA		
within 72 hours after death with the Marylan iene. "then "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Marri 3 XWidowed 4 Divorced	12. Was Deceding Armed Force 1 Tyes 2 If Yes, Given Year or Date	es? Γ√INo				spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, W Specify:	/hite, etc	
within ene. then	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 10		or 5+)	life.	kind of w	ork done d ise retired	lurina mosi	t of worki	ng		nd of Busine		•
9 X 5 -:	To Be C	17. Father's Name (First, Middle, James E. Jones	*							A. Ander		,		1001
nd 2 alth a 27 is		19a. Informant's Name/Relations Gene A. O'Dell				-				i <i>Route Number</i> rstown,				
T Se T		20a. Method of Disposition  1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)		ate	Place of Dispo cemetery, crei 111ace	natory or	other plac			11/20/C		cation · City		
permit. Page Department of Important: if any injury or pure		21. Signature of Funeral Service		nun	19	2. Name a	nd Addres	s of Facilit	y MI	NNICH F	UNEI	RAL HO	ME	
Physician / Medical Examiner put physician and physician and the prival-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due to (or	as a consect	quence of):		the	11/	1	m di		el	10	upproximate interval Between Onset and Death
ath certific attending p for use as	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 € No 9 □ Unknown		h 2 Feta nt at time of c	al death 3	Ectopic (	oregnancy pecify)					23d. Date of Month		ay Year
uires that the de	þ	Part II. Other significant condition	ns contributing to dea	th but not res	sulting in the u	nderlying	cause give	en in Part I.			bacco u	_	e to the	cause of death?
The taw ate hes b page 2 s	Completed									24a. Was a autop: perfor 1 Yes	sy	prior	to comp	y findings available tetion of cause of
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Hospital or Attending 24 hours after death. 5 Funerel Director: After etely filled in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place o	f Injury - At h , etc. <i>(Speci</i>	ome, farm, sti			.00		28f. Location (S City or Tow			r Rural I	Route Number,
To the Hospital or within 24 hours aft To the Funerel Discompletely filled in	edlcal C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the b Examiner: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my op	e, date an pinion, dea	d place, th occurr	and due to the c	ause(s)	and manne place, and	r as stat due to ti	ed. he cause(s)
vithir To th	ž	29b. Signature and title of certifier					c. License			Ä		e signed (M		
		ne					175	323	5		11.	-12-	20	07
511.7		30. Name and address of person	•		, , .									
DH-7		Dr. Khalid Wase	em, 1126 O	pal Co	urt, H	ager	town	, MD	2174	00				
Sta Registra		31. Date filed (Month Pay Year)	3 2007 32. Red	gistrar's Sign		acres la	Nie Williams							

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic exercises.

and burial-tran physician the use as has page 2

Physician/Medical Examiner 2 Completed

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 funeral director. After this To the Hospital or Attending after death. the

Be ( Certification: To 1 ☐ Yes investigation 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a. Certifier 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifile D005757 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlottte Hall, MD 20622 31. Date filed (Month, NOV Registrar

11-13-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2007 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 1.000 6:00 A.M **Physician** Gary Lee Pumphrey, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MARYLAND HEALTH CARE DERRY CEO /L POIN SYSTEM 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☑ M 2 ☐ F Yrs. 59 219-54-4186 Director Aug. 16, 1948 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? p or 7023 Dunbar Road, Apt. R permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a and bring or other traumatic event, the Medical Examiner must hone. 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∑Yes 2 No
If Yes, Give
Year or Dates: 1968 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Earl R. Pumphrey Ethel Dillo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aimee Saylor Eligibility Clerk Bldg. 361, V.A. Maryland Health Care System, Perry Point, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Cemetery 11/14/07 Owins Mills, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

SON - SON ALL BELL LUNG BARRING MARKET LUNG BARRING BARRING BARRING MARKET LUNG BARRING BAR Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): LUNG METASTASIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of) physician a Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? 1□ Yes 2 1 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

GARY KEE

NAME KNOWN TO PHYSICIAM: PUMPHARY,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: after death.

Director: / within 24 hours aft

To the Funeral Di

completely filled in

> 1 VA State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier Hast 29c. License number

1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEALTH PARESYSTEM, HER HASHMI

31. Date filed (Month, Day, Year)
NOV 1 3 32. Registrar's Signature Literar 2007

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State of Maryland / Department of Health and Mental Hygiene UU /	31	I I	J
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Physic	cian								Month	Day er 10 20	Year	3:34	
/Med		Charles Bradford  4a. Facility Name (If not institution, give			4b, City, Te	own, or	Location of		Novembe	4c. County		J. J.	
Exam	iner	Union Hospital	street and numbery		,,	1kto				Ced	cil		
Funera		5. Social Security Number 6. Se		e (In yrs. last birthda	y) If Under 1	Year	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birthpla	ace (State or	Foreign
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pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10	d. Inside City	y Limits
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filed Hygir		17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle,	Maiden Surnan	ne)		
id be ental ked c	To Be	Charles E. Pryon	r				J	ennie	e Dill				
Laily Idail of 1.6.1.5.1.5.00.50 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (T	ype. Print)	19b. Ma	ailing Address (	(Street a	and Numb	er or Rura	I Route Numbe	er, City or Town,	State, Zip	Code)	
and 2		Jo Anne C. Pryon	r/Wife							, MD 219			
of He roth		20a. Method of Disposition 1    Burial 2   Cremation 3 □	Removal from State	20b. Place of Dis					ate	20c. Location -	,		
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parifilliors, Inial yiallo ZIZIS-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	once	21. Signature of Funeral Service Licens	see /	/3	R . $T$ .	Foar	d Fu	neral	L Home,	P.A.		0101	_
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	8	23a. Fart1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final	4 /	1		3 4	1 11 2	م (ماء	_ , , )			Onset and D	Death
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COIGS, F.O. BOX DO/OU,  w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):									
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death cer e attendir ed for use	cian	23b. Was decedent pregnant in the past 12 months? 1 \( \times \) Yes 2 \( \times \) No	1 ☐Live birth 4 ☐ Pregnant at		3 □Ectopic pre 5 □ Other (spe		'	_		Mo	onth	Day Y	Year
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pital or At purs after d burs after d eral Direc	Certification.	4 ☐ Homicide determined	building, et	c. (Specify)					Only of For	wii, Olalej			
To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by			ysician: To the best	of my knowledge, d	eath occurred ir investigation	at the tir	me, date a	and place, eath occur	and due to the red at the time,	cause(s) and m date and place	nanner as st , and due to	ated. the cause(s	3)
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DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- Stete Amend #1 per phys, DOR, 11/8/07 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 04 Pinder 6:55 A M Car 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 2/3-23-5829 Usual Residence of Decedent Yrs. Director July 6, 1925 Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examinat must be notified at 1 Yes 2 PNo Director MD DorcheSter Linkwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S.
Armed Forces?
1 Larried 1 2183 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 Married 1 Never Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 9 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 Inent of Health and Mental Hygiene.
ant: If item 27 Is marked othar than "natury or othar traumatic evant, the McClean Elementary/Secondary (0-12) College (1-4or 5+) Lumber Company Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Poute Number, Gity or Town, State, Zip Code) inder 19a. Informant's Name/Relationship (Type, Print) 3930 Oceangate way
20b. Place of Disposition (Name of cametery, cramatory or other place) Linkwood, Maryland 21835

20c. Location - City or Town, State inder 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/07 permit. Page Department of Important: If any injury or Veterans Cemetery Hurlock, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY Funeral Home, P.A. 21. Signature of Funeral Service Licensee anelle Sio washington St. Cambridge, MD. 2/613 23a. Part I. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav signed by the at Id be detached fo 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🌠 No 24a. Was an autopsy performed? 2□ No 1 Yes Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{Specify} \) 1 Yes 2 No ပ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To tha Funaral C 29a. Certifier 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 17525 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. S. Wood, 22 31. Date filed (Month, Day, Year) S. Greene St.

Registrar

32. Regist

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ?

Certificate of Death

Year

Time of Death

2. Date of Death

Day

Month

**Physician** George Bernard Pelleu Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Silver Spring Riderwood Village If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 □ F 82 Director 304-20-3416 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at Director Md. Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 3146 Gracefield Road, Apt. #307 20904 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 □ No 1943 − If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗷 No ğ 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 8 Microbiologist 17. Father's Name (First, Middle, Last) Be is marked George В. Pelleu, Sr. Lucille 2 19a. Informant's Name/Relationship (Type. Print) Mildred D. Pelleu / Wife item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 0 1 Surial 2 ☐ Cremation 3 ☐Removal from State Parklawn Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Muri 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Parkinson's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Adult Failure to Thrive burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Yes 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 ☐ Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 25. Was case referred to medical examiner? Be Hospital: 10 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Injury 1 X Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number D59524 whuman Oveen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loveen J. Puthumana, M.D. 3110 Gracefield Road, Silver Spring, Md. 32. pgistrar's Signature

November 11 2007 5:30 A 4c. County of Death Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Nov. 22 1924 Indiana 10d. Inside City Limits 1 □Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry U. S. Government 18. Mother's Name (First, Middle, Maiden Surname) Merryman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3146 Gracefield Road, #307, Silver Spring, Md. 20904 Date 20c. Location - City or Town, State 11/15/07 Rockville, Maryland P. O. Box 5038, Laytonsville, Md. Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was a... autopsy performed? Ves 2 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) November 12, 2007 20904

State Registrar

Merca

			1 - For State Registrar	State of Ma	rylan		artmen <i>tificat</i>			and M	_	gienę. Reg. Nd:	/       /	37778
	Physici		1. Decedent's Name (First, Middle, Last)  James Price, Jr.								2. Date of De Month NOV	ath Day	Year 200	3. Time of Death
- Jane	/Medio Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death	1101	T	County of Dea	
			Anchorage Nursing	& Rehab C	ente:	r	Salisbury					Wicomico		
	Funeral Director		5. Social Security Number 6. Sep. 213–22–5768	1M 2DE	(In yrs. I. 87	ast birthday) Yrs.	Months Days Hours Min. (Month, D					ay, Year) Country)		
	pus *		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation			-				10d. Inside City Limits
	Aaryla r eho	ō	MD Wicomico			lisbur								Yes 2 No
	28a-	Director	10e. Street and Number		Ja	TISDUI	10f. Zip	Code	-			10g. Citi:	zen of What C	ountry?
	h with		4514 Allen Road					2180	)1				US	SA
	deat	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.		Was Dece	dent of His	spanic Original	gin? (Spe	city Yes or No Rican, etc.)	-	14. Race - Am Black, Whi	
336	iled within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23a or 28a-f ehow the than Medical Examinat must be notified at	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:	0		1 □ Yes		Specify:		, , , , , , ,	Specify: Black		
ğ	2 hou	ted	15. Decedent's Edu	cation	1	16a. Deced	dent's Usu	al Occupa	tion	t of working	20	16b. Kir	nd of Business	/Industry
212	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	<b>+</b> )	life.	DO NOT u	se retired)		OF WORKS	ig			
21	led wi lygien her th	Con	3				Lal	orer			(Films & Aldella	14-7-		ruction
Baltimore, Maryland 21215-0036	d a b >	To Be	17. Father's Name (First, Middle, Last)  James Price, Sr.				18. Mother's Name (First, Middle, M Nina Wallace						Sumame)	
ary	2 should have		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	i Route Numbe	er, City or	Town, State,	Zip Code)
Σ.	and 2 leelth m 27 i		Jerry Price/son		1	1			rive	·	dela S	•	<u> </u>	
ore	1 5 5 5		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	Ce	lace of Dispo emetery, crer	natory or o	ther place			ate	20c. Lo	cation - City or	r Town, State
<u>=</u>	t. Pa rtmen rtant: njury		4 Donation 5 Other (Specify)		Opi	inghil Gard					3/2007		lisbury	, MD
Ba	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licens	96		I 1	ewis 618 T	N. W Vest	atsoi Rd.	i Fur Sali	eral Hosbury,	ome MD:	21801	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the cause on each line	the death				-					Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition	Pros	tat	e C	arc	ino	ma					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	uence of):	/,,~	-0						
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	cate be executed oblysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events											
90	ate be executed hysicien and the burial-transit	EX	resulting in death) Last	Due to (or as a	consequ	ience of):								
8760	physicate t	dical		d										
9 X	eath certific ettending p	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of								2	23d. Date of de	livery
Box	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown			Ectopic p Other (s						Month	Day Year
P. O.	at the de	Phys	9 Unknown			ulain — in Albaniu			- in Dod I		220 Did t	obacca u	co contributo (	o the cause of death?
Division of Vital Records,	The law requires that the death certific lie hes been signed by the ettending p age 2 should be detached for use as	d by	Part II. Other significant conditions con	ithouting to death bu	t not rest	illing in the u	nderiying	ause give	in in Parti.			Yes 2[		robably 4 Unknown
Ö	s been si	olete									24a. Was		24b. Were a	utopsy findings available
8		Completed									autop perfo	med?	death?	completion of cause of s 2□ No
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ב	ding After fune	lon:	27. Manner of Death 1.☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	м	28c. Injury Work	at ? ∕es 2 🔲		28d. Describe I	now injur	y occurred	
/ISK	ten for: the	flcat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At ho	me, farm, str								lural Route Number,
á	s after s after al Dire	27. Manner of Death 1. Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Linury at Work? 1 Pres 2 No 28d. Describe how injury occurred 28d. Describe												
	To the Hospital or Attent within 24 hours after deetl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best o ner: On the basis of and manner stat	examinat	wledge, death tion and/or in	occurred vestigation	at the tim	e, date an pinion, dea	id place, a	and due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the H within 24 To the Fi complete	Mec	29b. Signature and title of certifier	2	1/ 1		29	c. License	number			29d. Dat	e signed (Mor	th, Day, Year)
	A		> Vulnipo	here	M	V	1	2006	39	91		1	1-07-	-2007.
•	18/2		30. Name and address of person who co	ompleted cause of de	ath (Item	23a) (Type,	Print)							
_	000		V. Anupama, 105				oury,	MD 2	21801					
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 8 21	32. Projistra	r's Signal	It. L	boule							

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dietrich A. Paul November16,2007 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number)

5:55

**Physician** /Medical Examiner

6000Harford Road

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Once.

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records.

Physician /Medical **Examiner** 

Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit page funeral director this s after deb. within 24 hours a To the Funeral L completely

Baltimore
ear | If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 XM 2 ☐ F Yrs 68 088-38-5015 Germany November 4, 1939 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6000 Harford Road U.S.A. 21214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🙀 No SpecifyWhite Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Bakery 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilhelmine Luise Gertrud Schafer Ernst August Paul 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Genevieve Brogan-Paul/Wife 6000Harford road, Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBunal 2 □ Cremation 3 □ Removal from State 11-20-07 Baltimore, Maryland Gardens of Faith 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P. A 6009Harford Road Baltimore, Marylandel 214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. amyotrophic Lateral Sclens is Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1∠Live birth 2 ☐ Fetal death
4☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 1/2001

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Phillips 900 Inda Vocuember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Merryland 6. Sex 5. Social Security Number twork Year | If Under 24 Hrs. f Under 1 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗙 🗙 59 018-38-7418 Director Nov. 24, 1947 Texas Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d, Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Maryland Frederick Frederick 1 XYes 2 □No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1805 Meadowgrove Lane 21702 USA 72 hours after death Funeral 12. 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Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Laurence S. Phillips- Husband 1805 Meadowgrove Lane, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State 5 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any in[ury or Parsons City Cemetery Nov 12,2007 Parsons, West 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign The of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home Maron [1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** disease or condition month resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 5 Other (specify) P.0. led by the a 9☐Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ pe 1 ☐ Yes 2 **V**No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The page perform certificate 2 No 2 No 1 ☐ Yes Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 npatient 2 ER/Outpatient 3□ DOA P After this 27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 M Natural 5 Pending (Month, Day Year) Injury To the nospinal within 24 hours after death. To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10

State Registrar 29b. Signature and title of certifier

)an

31. Date filed (Month, Day, Year)

B O YON

MO

None

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Marylano

			For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>			iene 2007	37781	
	Physici		Decedent's Name (First, Middle, La					2. Date of Deat Month	Day Yeer	3. Time of Death	
	/Medio		Carl Jacob  4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	November	3, 2007 4c. County of Dea	1030	
· is	Funeral Director	lei	Prince George s 5. Social Security Number 6.5	Hospital Cente		Chever1	y If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Prince  Pear)  9. Bit	George's  thplace (State or Foreign ountry)  ashington, DC	
	ס		Usuel Residence of Decedent					CEODEL 2	1720 K		
	arylar show	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits 1★ Yes 2 No	
	death with the Maryland ms 23s or 28s-f show rmst be notified at	Directo	Maryland Prince C	eorge's I	Jpper N	10f. Zip Code		1	0g. Citizen of What C		
	th wit		9501 Noble Drive	1		20772			United S	States	
re, Maryland ZIZID-UU30 s 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. Ifea 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 √ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2√2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Specify:		
5	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ition		16b. Kind of Business		
171	e filed within 7 al Hygiene. I other then "n vent, the ward	Completed	(Specify only highest gra Elementary/Secondary (0-12) 12 years	College (1-4or 5+)	life.	kind of work done d DO NOT use retired; Truck Dri		ang	Private		
<u> </u>	Hyg other	Be C	17. Father's Name (First, Middle, Last,	1		ILUCK DIA		e (First, Middle, M		**	
land	should be nd Mental marked o	ToB	Carl Jacob Redn	an			Clare	tta Duva	.11		
<u>a</u>	2 should be and Mental is marked or raumatic eve		19a. Informant's Name/Relationship (	** '					City or Town, State.		
£ ù	and and in 27 in 27 in tr		Yolanda Bryan - C					_	o, MD 2077		
altimore	permit. Pages 1 and 2 Department of Health a Important: If item 27 it any injury or other tra once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif	Removal from State	emetery, cre	visition (Name of matory or other place)  Vet s Cem	9)	1	20c. Location · City of 7 Chelter		
ם	permit. Page: Department of important: If is any injury or once.		21. Signature of Funeral Service Licel		22	2. Name and Addres	s of Facility Ste	wart Fun	eral Home,	Inc.	
All Control			23a. Part1. Enter the diseas , or com	plications that caused the deat	-					Approximate	
	Physician		shook or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Attal Ca	rdiac	aruk	ythru	a		Interval Between Onset and Death	
	/Medical Examiner			Due to (or as a conseq	uence of):		V				
	t insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
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00/00	physi s the b	edical		_ d							
	The law requires that the death certifies the same seem signed by the attending bage 2 should be detached for use a	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year						
č,	ires that t signed by d be deta	by P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	n in Part I.		pacco use contribute t	o the cause of death?	
ecords,	v requ been shoul	etec									
	The la	Completed						24a. Was a autops perform	y prior to	utopsy findings available completion of cause of s 2 No	
NII A	cian: ertific ector,	Be	25. Was case referred to medical examiner?	U-1-3-1	/			th (Check only on	θ)		
5	To the Hospital or Attending Physician: affinite 24 hours after death of the Funeral Director: After this certifical completely filled in by the funeral director.	on; To	1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital: 1 Inpatient 2 2  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		4   Nursing Ho		nce 6 Other (Special of the Control	ecify)	
	endir sath. or: Al	atlo	2 Accident investigation	n			es 2□No				
	al or Attends after death	Certification;	3 Suicide 6 Could not b 4 Homicide determined		28f. Location (St. City or Town	(Street and Number or Rural Route Number, own, State)					
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysicien: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat ition and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)	
	To the	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Mon	th, Day, Year)	
			1	11000	of	100	8957		11-5-07	-	
	(2)		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print)	J. 4.	0 20-			
			31. Date filed (Month, Day, Year)	● 32 Registrar's Signs	ure -	, away	AGE /K	0 00	(00)		
	Sta Registr		NOV 0 8 2007	32. Registrar's Signa	perti		J				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Paul Michael Righter 7:20 A M 9 November 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Morningside House Waldorf Charles If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 □ F 84 579-22-0618 Director August 25, 1923 District of Columbia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No St. Mary's Director Maryland Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24903 Maverick Court 20636 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant! if Item 27 is marked other than "natural", or iten uny or other traumatic event, the Medical Examiner ury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No White Specify. Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health Elementary/Secondary (0-12) College (1-4or 5+) Health Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul M. Righter Lavenia Ann Beatley ပြ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Richards / Daughter 10200 Angora Drive Cheltenham, MD 20623 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot November 16 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 uchael Kevr complications the 23a. Part1. Enter the disease, shock, or heart failure. L caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** alheroscler /Medical Due to (or as a consequence of) Examiner MONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as signed by the attending I be detached for use as IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>م</u> 2 No 3 Probably 4 Unknown 1 Tes certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 20 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASS 15.14 20 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Lirector: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person w o completed cause of death (Item 23a) (Type, Print) 1207001d We C+ +302 Vace

State Registrar 31. Date filed (Month, Day, Year) NOV 13

32 Registrar's Signature 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State MEND#23a, Pt. 1, perMD, 11/9/07, DPS, Moco Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10735AM Kuan largaret Ü 2007 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Examiner -ethesda Suburban Hospita lont-gomeny If Under 1 Year | If Under 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Sex 1□M 2AF Months Days Hours Dec. 12, 1916 Missouri 90 Yrs. 489-05-1782 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 sho lid be filed within 72 hours after death with the Marylar Department of Health and Nental Hygi ne. Important: if item 27 is marked other han "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. Maryland Montgomery Silver Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9727 Mt. Pisgah Road, #910 20903 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mortgage Banker Mortgage Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Morris Derfler Odella May Moore 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 182 Woodbine Drive Cranberry Township, PA 16066 David A. Wright -grandson Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 11/6/2007 Alexandria, Virginia 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Schemic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hovillagi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed NYZU use as the burial-tra a consequence of) attending physician for use as the buria 687 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Dav 5 ☐ Other (specify) signed by the O 9 ☐ Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The perform After this certificate Viital Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA o funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 31. Date filed (Ma legistrar's Signature State 2007 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 _ State	State of Marylan		rtment of <i>tificate o</i>			giene Rea. No.					
		-1	Registrar  1. Decedent's Name (First, Middle, Last)			imoute o	Dodin	2. Date of De	ath 2	007	3 Jime of pears			
Ç.	Physici /Medic			Izya ROZENB	AUM			Novembe	r 7, 2	2007	12:28 A <sup>M</sup>			
	Examin		4a. Facility Name (If not institution, give s	treet and number)			, or Location of Deat		4c. Co	unty of Death				
	** 	27	Holy Cross Hospi				r Spring			1ontgom				
p	Funeral Director		22U-31-4435 X	7. Age (In yrs. 79	Yrs.	If Under 1 Yes Months Day			v. Year)	Cour	lace (State or Foreign try) PUS			
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Loc	ation				1	0d. Inside City Limits			
	Mary -f sho	ţō	Maryland Montgome	arv	Silve	Sprin	n				1 □Yes 2 □ No			
	or 28a	irec	10e. Street and Number		311161	10f. Zip Code			10g. Citizen	of What Cour	ntry?			
	23a cust b	Funeral Directo	1135 University Bl	vd., W. #301			0902			ed Stat				
	er dea	nne	TT. Wantar Clarac	2. Was Decedent Ever in U. Armed Forces?	S. 13. W	as Decedent of Yes, specify C	f Hispanic Origin? (S uban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14.	Race - Americ Black, White,				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy lury or other traumatte event, the Medical Examiner must be notified at once.	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∏ Yes 2 ሺ No If Yes, Give Year or Dates:	1	□Yes 2XIN	lo Specify:	specify: Specify: White						
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2	iled w Hygiel <b>ther th</b> nt, the	S	17. Father's Name (First, Middle, Last)	5+	l ea	acher	18 Mother's Na	me (First, Middle,		ucation				
Maryland 21215-0036	d be f ental h ced ol	o Be	Abram Gor	elik				na Rozen		mame)				
ary	shoul ind M is marl umati	၉	19a. Informant's Name/Relationship (Typ				et and Number or R	ural Route Numb	er, City or To					
	and 2 salth a 27 is er tra		Anna Roshal, Daugh				od Court,	Silver	Spring	ı, MD	20906			
altimore,	Jes 1 at 1 of He in them		20a. Method of Disposition  1)☐ Burial 2 ☐ Cremation 3 ☐ Re			ition (Name of natory or other		Date		ion - City or To	,			
Ħ.	thent tant:		4 Donation 5 Other (Specify) Mt. Lebanon Cemetery 11/08/0/ Adelphi, MD											
Ba	Depart Depart Import any in		21. Signature of Funeral Service License	,						50 0	0010			
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	sit ad	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Chronic Kid		92592				7.0				
Br.	icate be executed physician and s the burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a conseq		Jease								
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Š	th cer tendin r use	an/N	23b. was decedent pregnant	3c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta		Ectopic pregna	ncy		230	23d. Date of delivery  Month Day Year				
Records, P.O. Box	e dea the at red fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown		Other (specify,				Month	Day Year			
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ds	uires 1 sign 1d be	d by			_			1 🗆	Yes 2□1	No 3 ☐ Prol	oably 4 Unknown			
O O	aw requir s been si 2 should	Completed						24a. Was	an 2	24b. Were auto	ppsy findings available			
<u>~</u>	The lay	mo						auto perfo 1□ Yes	psy ormed? 2A No	death?	mpletion of cause of 2□ No			
Division or Vital	ctor.	Be C	25. Was case referred to medical examiner?					eath (Check only o						
7	Physician: The la r this certificate has ral director, page 2	은	1 ☐ Yes 2 No		ER/Outpatient	O DOA		Home 5 ☐ Resi			(y)			
n C	ding F	ion:	27. Manner of Death  1  Natural 5  Pending  2  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Vork? □ Yes 2 □ No	28d. Describe	how injury o	ccurred				
<u>ISI</u>	death death cctor: y the	Certification:	3 Suicide 6 Could not be	28e. Place of injury - At ho	pme, farm, stre					lumber or Rura	al Route Number,			
á	al or a after	Serti	4 ☐ Homicide determined	building, etc. (Specif	<i>y)</i>			City or To	wn, State)					
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical C		sician: To the best of my knowner: On the basis of examina and manner stated.										
	To the Within To the comple	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date s	igned (Month,	Day, Year)			
	1		1	D65305							2007			
	1	:    -	30. Name and address of person who co Nabila Khan, M.D.,	mpleted cause of death (Item 1500 Forest	n 23a) (Type, I Glen R	oad, Si	lver Spri	ng, MD	20910					
	Sta		31. Date filed (Month Cav. Year) 20	32. Signatura Si	ature	ecell 1								

Kobe	rt A. Riley		- For State		ent of Health and Mental H ate of Death	rygiene Reg.	No. 200	7 37785			
	Physici	an/	Registrar  1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death			
Medi	cal Exami	ner	Robert A. Riley  4a. Facility Name (if not institution, give street a	and numbers	4b. City, Town, or Location of Deat	Month Do October 15,	2007 4c. County of Death	2057 hrs			
. ,		,	18401 Guildberry Drive #102	ina namber)	Gaithersburg	"	Montgomery				
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24Hr Months Days Hours Mir		MM/DD/YYYY) 9. Bir Foreig				
	Director		209-56-5407 1XM 2	F 44	Yrs. World's Days Trouts Will	04/20/19	963 <sup>co</sup>	untry) PA			
	any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location	10d. Inside City Limits					
	≥	۱	Maryland Montgomery	Gaith	nersburg			1 Yes 2 X No			
	Maryland 28a-f show d at once	rectc	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	ntry?			
$\stackrel{\smile}{=}$	ith the 23a or notifie	١	18401 Guildberry Dr	tve #102	20879  13. Was Decedent of Hispanic Origin? ( S		nited Stat	es ican Indian, Black,			
	eath wi items ust be	Funeral Director	1 Never Married 2 X Married An	med Forces?	If Yes, specify Cuban, Mexican, Puert		White, etc.	lear mulai, black,			
	after d al", or iner m	by Ft	3 Widowed 4 Divorced If Yes, G		1 Yes 2 X No specify:		Specify: Whi				
	hours natur	ted t	15. Decedent's Education (Specify only higher Elementary/Secondary (0-12)  Col		Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		6b. Kind of Business/ Montgomer				
Ş	J36 thin 72 re. than '	Completed	Elementary/Secondary (0-12)	4	Teacher		Public Sc				
č	5-07 liled wi Hygier I other		17. Father's Name (First, Middle, Last)		18.Mother's Nam	e (First, Middle, Mai	iden Surname)				
3	Z1Z15-UU36 Z1Z15-UU36 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Kenneth Riley 19a. Informant's Name/Relationship (Type, Prin	nt ) 19t	Joseph Jo	ine Russe		a. Zip Code)			
Ì	AD 2 shouth and 1 street 1 str		Patricia Riley / Wii	- 1	3401 Guildberry Dr.	#102, Ga:	ithersburg	, MD 20879			
	ITE, I s I and if Heali If item		20a. Method of Disposition  1 Burial 2 X Cremation 3 Rem		f Disposition (Name of cemetery, ory or other place)	Date 2	20c. Location - City or	Town, State			
	BAITIMOFE, MID Z1Z15-UU36 pernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Tiem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify:		olitan Crematory 10	0/18/07	Alexandri	a, V <u>A</u>			
Č	Eall permit Depart Impor		21. Signature of Funer Service Licensee	_	22. Name and Address of Facility Si			0852			
}	Physician		23a. Part I. Enter the disease, or complications failure. List only one cause on each line.	that caused the death. Do no	t enter the mode of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and			
	/Medical xaminer		Immediate Cause (Final disease a. Hypo		clerotic cardiovascuklar	disease		Death			
			, h	or as a consequence of):							
		ner	if any, leading to immediate Due to (	or as a consequence of):							
B		Examine	(Disease or injury that initiated C	or as a consequence of):							
	cecuted 1 and - trans	alE	d								
9	LIVISION Of VITAL RECORDS, P.O. BOX 68/6U, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	X UNPENDED AME	3a,27,perME,g873 f yes, outcome of pregnancy	, 11/29/07 TT		23d. Date of deliver	l v			
í	ertifical ding ph	an/N	23b. Was decedent pregnant in the past 12 months?	Live birth 2	Fetal death 3 Ectopic pregi	nancy		Day Year			
	SOX leath c e atten for us	ysici	1 Yes 2 No 9 Unknown 9	Pregnant at time of death Unknown	Other (Specify)						
	inat the card by the etached		Part II. Other significant conditions contrib	uting to death but not resulting	g in the underlying cause given in Part I.		acco use contribute to				
C	S, F uires th n signe Id be d	ed by				1 Yes -   24a. Was an		utopsy findings available			
	Ord law req has bee 2 shou	Completed				autopsy perform	prior to	completion of cause of			
ć	KeC : The ificate r, page	S	25. Was case referred to medical		26.Place of Death (Chec	1 Yes 2	No 1 <b>✓</b> Y	res 2 No			
	VITAI ysician his cert directo	o Be	examiner?  1  Yes 2  No	1 Inpatient 2 ER/O	I Othor:		esidence 6 🗸 Othe	er: Scene			
5	DIVISION OT VITAI KECOTOS, pital or Attending Physician: The law requir ours after death. After this certificate has been s filled in by the funeral director, page 2 should	n: To	27. Manner of Death	. Date of Injury (Month, Day,Year) 28b.	Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred				
	SION Attend death. ector:	catio	Natural 5 Pending Investigation	Diago of Injury. At home for	1 Yes 2 No	28f Location (Str	eet and Number of P	ural Route Number, City			
	DIVIS tal or / rs after al Dire	Certification:	Suicide Could not be	e. Place of injury - At nome, to pec <i>ify)</i>	arm, street, factory, office building, etc.	or Town, Sta		drai Notice Namber, Orty			
	DIVISIOF  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only)									
	To the Hos within 24 h To the Fur	Medical	and ma	basis of examination and/or i nner stated.	nvestigation, in my opinion, death occurred		nd place, and due to t 29d. Date signed <i>(M</i>				
	V	2	29b. Signature and title of certifier	<i>!</i>	29c. License number O.C.M.E. 00		October 16, 200	_			
	7		30. Name and address of person who complete	ad cause of death (Item 23a)	w)						
				ssistant Medical Exam	iner 111 Penn Street, Baltimo	ore, MD 21201					
	S Regis	tate trar	31. Date filed (Month, Day, Year) NOV 2 1 2007	32 Registrar's Signature	Gode						
_		_			- <del></del>						

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV

8 2007

**ORIGINAL** 

32. Registrar's Signature

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State of Mar	yland / Department of	Health and Me	ntal Hygien	UU	l

		·	For State Registrar		Maryland	d / Depa	artmen rtificate	t of H	ealth a Death		F	Reg. No.	007	37787
Y	Physic	ian	Decedent's Name (First, Middle								Date of Dea Month		_Year_	3. Time of Death
	/Medi	cal	Florence Jea								Month Novemb			6:30 p. M
	Exami	ner	4a. Facility Name (If not institution	_	er)				Location o	t Death			County of Death Dorches	
	-	\$ /	5. Social Security Number	Chesapeake Woods Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday						24 Hrs. R	. Date of Birt			
	Funeral Director		218–10–8047	1□M 2□	92	Yrs.	If Under Months	Days	Hours	Min.	(Month, Day	y, Year)		place (State or Foreign intry)
			Usual Residence of Decedent							<i>E</i>	lug. 19	9,	915 Mar	ryland
_	Maryland -f ehow	_	10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
$\downarrow$		cto		chester					Cambr	ridge				Maria Yes 2 No
3	72 hours atter death with the Maryla natural; or itame 23a or 28a-f ehov iteal Exagrimer must be souttled at	Director	10e. Street and Number	3			10f. Zip		11.61.3			10g. Citiz	zen of What Cou USA	intry?
2	e 23e	Funeral	525 Glenburn	Avenue	ot Cues in 11 S	2 12	Man Dance		21613	:-2 (C	h. V N	iona Indian		
0	ter d	L.	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed Force	s?	3. 13.	If Yes, spec	offy Cuba	n, Mexican	, Puerto Rio	y Yes or No- can, etc.)		<ol> <li>Race - American Black, White</li> </ol>	
920	urs al	þ	3 Widowed 4 □ Divorced	If Yes Give	_		1□ Yes 2	ZX No	Specify:				Specify: whi	ite
2-0	72 ho	Completed		t's Education st grade completed)		16a. Dece	dent's Usua	I Occupa	ition	of working		16b. Kir	nd of Business/Ir	ndustry
21	en .		Elementary/Secondary (0-12)	Coflege (1-4d	or 5+)	(Give kind of work done during most of workii life. DO NOT use retired)								
2	e filed wi I Hygien other th		10	1 11		1	ine w	orke				_	anufactu	ırer
and	I be filed ntal Hyg ed other: event,	Be	17. Father's Name (First, Middle, Noble Andrew		h						First, Middle, IcGlaud			
Š	hould d Me mark matic	P	19a. Informant's Name/Relations		1	10h Maili	na Addrace	/Street :				_	r Town, State, Zi	in Code)
Maryland 21215-0036	es 1 and 2 should be fi of Health and Mental H fitem 27 is marked ot r other treumatic ever		Pat Windsor	p.:	r.		-				Cambr:			613
	f Heal		20a. Method of Disposition	P.V.	20b. Pl	ace of Dispo	sition (Nan	ne of	1	Dat			cation - City or T	
Baltimore,	Peges ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		10	cheste	-		· 1	11/8/	07	Car	mbridge,	MD
alti	permit. Peg Department Important: if any injury o		21. Signature of Funeral Service				2. Name an				the state of the s		al Home	
m	Dep imp		that I	377			700 I	ocus	t St.	, Can	bridge	e, M	21613	3
	Physician /Medical Examiner	niner	23a. Part # Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	, 30011 43	saidiac oi i	ospiratory at	1631,		Approximate Interval Between Onset and Death					
,68760,	The law requires that the death certificate be executed the hes been signed by the attending physicien and page 2 should be detached for use as the buriat-transit	Medical Examin	that initiated events resulting in death) Last	d	as a consequ									
P.O. Box	thet the death certific ed by the attending p detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ancy al death 3 Ectopic pregnancy death 5 Other (specify)					23d. Date of Month			very Day Year		
S,	es the igned be de	þ	Part II. Other significant condition	2		-		_	n in Part I.					the cause of death?
ord	w requir been si should	ted	_ chronic c	DOSTILLATION	re 14	ngo	11 Sec	≥se_			101	res 2	No 3□ Pro	bably 4 Unknown
Division of Vital Records,		Completed			ilure	2							24b. Were aut prior to c death?	topsy findings available ompletion of cause of
Ζ		Be	25. Was case referred to medica examiner?	Hospital:				Othe			Check only o			
of	g Physier this	. To	1 Yes 2 No 27. Manner of Death	28a. Date of I		ER/Outpatie		JA	4 XNU		d. Describe I		Other (Spec	ufy)
on	들을	tlor	1 Naturaf 5 Pendir 2 Accident investi		Day Year)	fnjury	М	8c. Injury Work	:? /es 2 □ !				,	
Divisi	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 289. Place of	fnjury - At ho etc. (Specify	me, farm, st	street, factory, office 28f. Locatio					on (Street and Number or Rural Route Number, r Town, State)		
	To the Hospitel or Al within 24 hours after of To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical one)	ng Physician: To the be Examiner: On the basis and manner	s of examinat	wledge, deat ion and/or in	vestigation	, in my or	pinion, deal	d place, an th occurred	at the time,	date and	place, and due	to the cause(s)
	witl To CO	Σ	29b. Signature and title of certifie	· · · · · · ·					number		-	/	e signed (Month	. Day, Year)
			ganns	on			H	60	599	73			6/07	
			30. Name and/address of person	who completed cause of hin SON	of death (Item	Bram	Print)	/	1 mil	buil	90 1	110		
300	St	ate	31. Date filed (Month, Day, Year,	32. R	strar's Signat		DIC.	•	JUINE	mia	70	121		
	Regist		NOV 0	8 2007	Com.	B. A	Chorles Contraction	20						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month RUTY ROGNESS 5, 200 **Physician** (0:35 A M November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOVR (mol) 125tmins If Under 24 Hrs. 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 🕍 🗆 F Yrs. Iowa Director 89 August26,19|18 479-48-0610 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show ner must be notified at 1 X Yes 2 No Director Westminster Maryland Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21157 300 St. Luke Circle by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or II edical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any lipiny or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Frieda Schmidt Martin Letsche ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1607Davinda Drive Finksburg, Maryland 21048 Joan Graen / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Riverside Cemetery 11/21/07|Spencer, Iowa 4 Donation 5 Dother (Specify) 21. Signature of Funeral Şervjce Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A Road Baltimore, Maryland21214 23a. Part1. Enter the disease, or coru fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician DOYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, ර Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 2 No 3 Probably 4 □Unknown 1 ☐ Yes filled in by the funeral director, page 2 should To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? (es 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 105 P(C 1 Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 ☐ Pending М 1 Tyes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 100059943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lom (1) 295 32 Registrar's Signature 31. Date filed (Month, Day, Year. State

DHMH 17 Rev 1/2001

Registrar

6 2007

07-08539 Doween Xavier	Simi	Please Type or Print in Black Indelible Ink.			gible.	
Doween Aavier		1- For State Amond #19 Dor FUDCC11 9 07-Gertificate of De		_	200	17 3778
Physicia		1. Decedent's Name (First, Middle,Last)		2. Date of Dea	eg. No. ZUL	3. Time of Death
Medical Exami		Doween Xavier Simpson		Month Novembe		0105 hrs
4			ity, Town, or Location of Death neverly		4c. County of Dea Prince Georg	
Funeral			Under 1 Year   If Under 24Hrs	8. Date of Bir	rth(MM/DD/YYYY) 9. B	
Director		577-17-1975 1X M 2 F 25 Yrs.	onths Days Hours Min.	05/15/	Fore	
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
<u> </u>	Ē	Maryland Prince George's Bowie				1 X Yes 2 No
Maryland 28a-f show d at once.	Director		. Zip Code	1	10g. Citizen of What Co	untry?
3a or		4806 Wills Vision Drive	20720		Jamaica	n
th with ems 2:	Funeral		cedent of Hispanic Origin? (Sp pecify Cuban, Mexican, Puerto		o- 14. Race - Ame White, etc.	rican Indian, Black,
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Hearth is demail Hygiens in the Maryland Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	1 Yes 2 X No	2 X No specify:		Specify: E	lack
hours natur Exami		during most o	sual Occupation (Give kind of v f working life. DO NOT use reti		16b. Kind of Business	/Industry
215-0036 be filed within 72 ntal Hygiene. Red other than "ent, the Medical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12 Loan 0				1 Mortgage
15-C filed v I Hygi d oth		17. Father's Name (First, Middle, Last)			Maiden Surname)	
212 buld be Menta marke ic even	To Be	Earl Simpson  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Add	Iress (Street and Number or F		nson Tomlin mber, City or Town, Sta	
MD nd 2 sho alth and m 27 is	-		lls Vision Dri	ve, Boy	wie, MD 20	720
re, f I and Healt Fitem er tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other p	(Name of cemetery,	Date	20c. Location - City of	or Town, State
MO) Pages nent of		4 Donation 5 Other Specify: Harmony Mem.	Park. Cem11/	17/2007	Landover,	MD
Baltimore, permit. Pages I an Department of Hea Important: If itel		21. Signature of Funeral Service License 22. Name	and Address of Facility For Bladensburg Ro			Home 20722
Physician /Medical		23a, Part I. Enter the disease, or complications that caused the death. Do not enter the management of the property of the cause on each line.	ode of dying, such as cardiac o	r respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
taminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):				Death
	ē	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	xaminer	cause Enter Underlying Cause (Disease or injury that initiated				
cuted md transit	ш	events resulting in death) Last  Due to (or as a consequence of):  d.				
be exe ician a	dica	UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans.	sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal di 4 Pregnant at time of death		ancy	23d. Date of delive Month	ery Day Year
30x death ne atter	ysic	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	(Specify)			
P.O. F ss that the gned by the	by Phys	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	-	tobacco use contribute	to the cause of death?
ds, equires	eted			24a. Was		autopsy findings available
CCOF The largane has bage 2 sh	Completed			auto perfo 1 <b>Y</b> Yes	ormed? death'	
of Vital Rec ling Physician: The After this certificate funeral director, page	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)		
F Vit	70	1 Ves 2 No Inspirer 1 Inpatient 2 V ER/Outpatient 3		ng Home 5	Residence 6 Oth	ier:
on or rending l sath. or: Afte		27. Manner of Death  1 Natural 5 Pending Nov 3, 2007 28b. Time of Injury 0012 hrs	28c. Injury at Work?  1 Yes 2 ✓ No	Subject sho	how injury occurred ot	
Division of Vital Records, within 24 hours after denting Physician: The law require to the Funeral Director: After this certificate has been st completely filled in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Bar/tavern		or Town,		Rural Route Number, City
D To the Hospital within 24 hours To the Funeral completely filled		4 ✔ Homicide (Specify) Bar/tavern  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a				
n 2 he l	<b>Nedical</b>	one) 2 Medical Examiner:On the basis of examination and/or investigation, and manner stated.				

State

31. Date filed (Month, Day 107) Registrar DHMH 17 Rev 1/2001 OCME 2006

Assistant Medical Examiner

32. Registrar's Signat

30. Name and address of person who completed cause of yieldh (Item 23a)

Theodore M. King, Jr., MD.

29c. License number

O.C.M.E.

OCME

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 3, 2007

			For State Registrar	State o	of Maryland		artment or <i>rtificate</i>				giene Reg. No	000	37700
			negistrar     Decedent's Name (First, Mid	dle, Last)						2. Date of De	ath	2001	3. Time of Death
3	Physici		David S. Schlesinger							Novembe	er T	200 <sup>7</sup> ar	10:00 A M
	/Medio		4a. Facility Name (If not institution	_					cation of Death		40	. County of Deatl	
			Montgomery G	enerAL Hos				Olney					gomery
1	Funeral		5. Social Security Number	6. Sex 1 <b>T</b> M 2 ☐ F	7. Age (In yrs. last birthday) 96 Yrs.				Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ıy, Year		nplace (State or Foreign untry)
0	Director		579-16-4012 Usual Residence of Decedent	A						April:	29,	1911 Hur	ngary
	land ow		10a. State 10b. Coun	ty	10c. City,	Town or Lo	cation					-	10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	tor	Maryland Mont	gomery	Si	lver	Spring						1 X Yes 2 □ No
	th the or 28% e noti	Director	10e. Street and Number				10f. Zip C	ode			10g. C	itizen of What Co	untry?
	23a ust b	ral	3330 N. Leisur					20906				U. S. A.	
	r dea terms	Funeral	11. Marital Status	Armed Fr	cedent Ever in U.S orces?	5. 13.	Was Deceder If Yes, specify	nt of Hispa / Cuban, N	anic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	)~	<ol> <li>Race - American Black, White</li> </ol>	
36	s afte	by F	1 □ Never Married 2 → Married		2 XNo ive Dates:		1 ☐ Yes 2	XNo S	Specify:			Specify:	√hite
21215-0036	2 hour	ed	15. Deced	ent's Education	-	16a. Dece	dent's Usual	Occupatio	n	· ·	16b. l	Kind of Business/	Industry
215	hin 7% an "na Media	plet	(Specify only high Elementary/Secondary (0-12	hest grade completed) College (	(1-4or 5+)	(Give life.	DO NOT use	aone aurii retired)	ng most of work	ing			_
21	filed withi Hygiene. other than	Completed	12 Years		`		Owner			.=			ontractor
Ø	be filed v tal Hygie d other i event, th	Be	17. Father's Name (First, Middle					18	. Mother's Name Miriam	•		n Surname)	
yla	should be nd Mental marked o matic eve	ျ	Samuel Sch			10h Maili	na Address (6	Stroot and				or Town, State, Z	Zin Code)
Mar	d 2 sh th and 7 is n traun	1	19a. Informant's Name/Relatio		*** C				e World		# :	Silve:	r Spring, MI
e,	1 and Healt erm 2	1 9	Sylvia M. Sch 20a. Method of Disposition	<u>lesinger</u> -	20b. Pl	ace of Dispo	sition (Name	of		Date Date	20c. L	ocation - City or	-20906 Town, State
noi	ages ent of ht: If It		X☐ Burial 2☐ Cremation 4☐ Donation 5☐ Other				matory or oth id Mem		ns 11/4,	/2007	Fa]	lls Chur	ch, Virginia
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic ev once.	1 8	21. Signature of Funeral Servi	-							CTIC	ON, INC.	
ä	permit Depar Impor any ir	ė. ()	Donald	. Xton	temuck	_   1	091 Ro	ckvi.	lle Pi <u>k</u>	e, Rock	vil	le, Mary	land 20852
ĸ.	4		23a. Part1. Enter the disease, shock, or heart failure. L	or complications that ist only one cause on	caused the death each line.	. Do not en	ter the mode	of dying, s	such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
No.	Physician		Immediate Cause (Final disease or condition	. Res	spiration	failur							Onset and Deadi
	/Medical		resulting in death)	Due to	(or as a consequ	ence of):							
B	Examiner	<u>h.</u>	Sequentially list conditions, if any, leading to immediate  b. Peuru ethsic  Due to (or as a consequence of):										
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	2	igestue 1		factor					- 0	
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8760,	cate be executed oblysician and the burial-transit			d									
9	tificat ng ph) as th	Physician/Medical						_				-	
Box	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou 1□Live	utcome pf pregnai birth 2 ☐ Fetal		□Ectopic pre	gnancy			10	23d. Date of del Month	ivery Day Year
	e dea the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of de nown	eath 5	Other (spec	cify)					24,
P.0	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	F.	Part II. Other significant cond	itions contributing to	death but not resu	Iting in the L	Inderlying cau	se given i	in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
ds,	signe d be d	l by		3						10	Yes	2  No 3 Pi	robably 4 🛮 Unknown
COL	w require been sig	Completed								24a. Was	an	24b. Were au	utopsy findings available
Re	The lav	m d									ormed?	death?	completion of cause of 2 □ No
Vital Records,		Ö	25. Was case referred to medi	cal	·		_	20	6. Place of Deat	1 Yes th (Check only	2 <b>P</b> N one)	10 10163	2 140
Ž	ys di is	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Impatient 2 □ I	ER/Outpatie	nt 3□ DOA	Other:	4 ☐ Nursing Ho	ome 5□Res	idence	6 □Other (Spe	cify)
n or	ding Ph After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pen	(1140	e of Injury onth, Day Year)	28b. Time of Injury		c. Injury at Work?		28d. Describe	how inj	ury occurred	
Sio	Attending r death. ector: After by the fune	catio		stigation			M To story		s 2∏No	20f Lagation	(Ctroot	and Number or P	uml Pouto Number
Division	5 # ± c	Certification:		rmined 200. Flat	ce of injury - At hor ding, etc. (Specify	me, tarm, si	reet, factory,	опісе		City or To	own, Sta	and Number of Hi ite)	ural Route Number,
	pital ours a erai [		29a. Certifier 1 Certif	ying Physician: To th	ne best of my know	wledge, dea	th occurred a	t the time,	date and place	, and due to the	e cause	(s) and manner as	s stated.
	e Hos 24 h e Fun etely	Medical	(Check only 2 Medic	eal Examiner: On the	basis of examinat inner stated.	ion and/or i	nvestigation, i	n my opin	ion, death occu	rred at the time	, date a	ind place, and du	e to the cause(s)
	To the Hospital c within 24 hours at To the Funeral D completely filled is	Me	29b. Signature and title of cert	Per				License n				ate signed (Mont	th, Day, Year)
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	10	(	30. Name and address of pers					obert	t Kirkca	aldy, M	D		
			18101 Prince	Philip Driv	le, oher	Many	امیط						
- K.	St Regist	ate rar	31. Date filed (Month, Day, Ye NOV 0	9 2007	gistrar's Signa	M A	back .						
	ricgist				reserved 1	155							

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month

egistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Da 10/19/2007 17:40 PM Donald Franklin Savage 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Chester River Hospital Center Chestertown Kent If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 5/4/1942 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 XM 2 ☐ F Months 448-42-9995 65 IN Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No MD Queen Anne's Millington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 421 Chester River Heights Rd. 21651 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) County Inspector 12 2 Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roger Savage Rose McNeill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Savage/wife 421 Chester River Heights Rd. Millington, MD 21651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Cremation | 10/25/2007 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein&Newnam Kuk X 130 Speer Rd. Chestertown, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day s a conse µence of: ue to (or Heriosilero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No **►** Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

**Physician** /Medical Examiner requires that the death certificate be executed

physician

attending

certificate Physician:

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To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

Examiner

burial-transit the as for use cate has been signed by the a page 2 should be detached funeral director,

Physician/Medical **∂** Completed Be ဥ Certification: filled in by the

Natural 5 Pending 2 Accident

3 Suicide 4 Homicide

(Check only

29a. Certifier

investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🕦 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certific

an

and manner stated.

29d. Date signed Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date fled (Month, Day, Year)

am 12 32. Registrar's Signature

State Registrar

completely

Medical

		State of Maryland / Dep		lental Hygie	ne
	_	- Hogistiai	rtificate of Death	Reg.	NO2007 37793
Physicia	an	Decedent's Name (First, Middle, Last)  ONT THE		2. Date of Death Month NOV . 4 ,	Day 2007   3. Time of Death   3. Time of Death   1648 M
/Medic		PHYLLIS A. SMITH  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	· · · · · · · · · · · · · · · · · · ·	4c. County of Death
Examin	er	Montgomery General Hospital	Olney		MONTGOMERY
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day Ye Jan . 26	9. Birthplace (State or Foreign Marryland
pui »		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Letter (County)	ocation		10d. Inside City Limits
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	ō		lney		1 XYes 2 □ No
the h	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
h with	al D	17415 Old Baltimore Road	20832		U.S.A.
r deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
s afte ; or it	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Black
tural	ed b	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b	. Kind of Business/Industry
hin 72 e. an "na Medic	plet	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of worki DO NOT use retired)	ing	U.S. Postal
ed wit ygiene er tha	Completed	12th	Postal Clerk		Service
be file	Be	17. Father's Name (First, Middle, Last)  Walter Awkard		e (First, Middle, Maid Ce Snowō	,
hould Mer marke	မ		ng Address (Street and Number or Rura		
and 2 s ealth an m 27 is ner trau		Connie L. Williams (Daughter)	P.O. Box 2433		
ss 1 a of Hear item		20a. Method of Disposition 20b. Place of Disposemetery, cre	osition (Name of Ematory or other place)	Date 200	. Location - City or Town, State
Pages ment of I ant: If ite ury or o		4 Denation 5 Other (Specify) Mutual	Mem Cem 11/		Sandy Spring ,MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1				NERAL HOME, P.A. ockville, MD 20850
		23a. Part 1. Enter the disease, or comblications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition tesulting in death)	K		Onset and Death
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	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events .			
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leath certific: attending pl	/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			22d Data of delivery
The law requires that the death certific tte has been signed by the attending p age 2 should be detached for use as	Physician/Me	in the past 12 months?	⊒Ectopic pregnancy ☐ Other <i>(specify)</i>		23d. Date of delivery  Month Day Year
that the dened by the stacked	hysi	9 ☐ Unknown			
res tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
w requir been si should I				1 ☐ Yes	2 No 3 Probably 4 Onknown
ne law has b	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
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ig Phy ter thi neral c	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how i	
endin sath. or: Aff he fur	atio	2 Accident investigation	M 1 Yes 2 No		
s after de al Direct	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
To the withing to the composite comp	Me	29b. Signature and title of certifier H	29c. License number	29d.	Date signed (Month, Day, Year)
10		30, Name and address of person who completed cause of death (Item 23a) (Type	Print) Print) Pulin in	rive N	NOU MD 20832
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	and position of	IV OU	The war
3.7.		Transfer of the			

State of Maryland / Department of Health and Mental Hygiene

		Testate Amend #5 Per Inf G874 12/17/(  1. Decedent's Name (First, Middle, Last)	OCe <b>H</b> ficate of	Death		1. No. 2007	37794
Phys	siciar	Carlita Talbott Speake			Month November	4:30 p M	
	edica	4a. Facility Name (If not institution, give street and number)	4b. City, Town,	4b. City, Town, or Location of Death			1.30 P
Exa	mine	11060 Weymouth Court	Waldor			Charles	
Fune	rai	5. Social Security Number 6. Sex 7. Age (In yrs. last be	oirthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	9. Birth	nplace (State or Foreign untry)
Direct		215-44- <del>5086</del>	Yrs.	riours iviii.	Sept.4,	1930 Wes	t Virginia
pug 🔉		Usual Residence of Decedent  10a, State 10b, County 10c, City, Tow	wn or Location				10d. Inside City Limits
Aaryla Fshored at	1	1000000					1 ∐Yes 2 XNo
the N 28a-	100	10e, Street and Number	10f. Zip Code		100	J. Citizen of What Co	untry?
death with the Maryland ms 23a or 28a-f show r must be notified at	Ë	11060 Weymouth Court	2060	13		U.S.A.	
death ms 2 r mus	10000	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cul		ecify Yes or No-	14. Race - Amer Black, White	
III (A I Z I S-UUSO be filed within 72 hours after death with the Marylar tal Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ű		1 ☐ Yes 2 🔯 No		moan, etc.)	Specific	
hours af	1	3 by Wildowed 4 □ Divorced   Year or Dates:				AATT	ite
n 72 m	o to to to to to to	15. Decedent's Education 16a (Specify only highest grade completed)	<ul> <li>Decedent's Usual Occu (Give kind of work done life. DO NOT use retire</li> </ul>	e during most of work	ring	6b. Kind of Business/I	ndustry
within lene.	8	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker	,		Her Home	
E filed Hygother	0	17. Father's Name (First, Middle, Last)	Officialists	18. Mother's Nam	e (First, Middle, Ma		
il yialiu A should be filed nd Mental Hygi marked other matic event, ti	F			Zada Gr	iffin		
2 should and Men is marke	'		b. Mailing Address (Stree	t and Number or Ru	ral Route Number, (	City or Town, State, Z	ip Code)
is 1 and 2 should by Health and Mer Item 27 is marke other traumatic.			0700 Ashford				
Sec 1		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Disposition (Name of tery, crematory or other pla muxen United	ace) Nov. 10	Date 2007	Oc. Location - City or	Town, State
Pages ment of tant: If its		4 Donation 5 Other (Specify) Chical			t Church	Chicamux	en, Maryland
permit. Pages Department of Important: If it any Injury or or	nce.	21. Signature of Funeral Service Licensee	22. Name and Addr Williams	There are 7 I	lome, P.A.		
	O	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	4270 Hawt	horne Rd.	, Indian	Head, Md.	20640 Approximate
	8	shock, or heart failure. List only one cause on each line.	o not enter the mode of dy	ing, such as cardiac	or respiratory arres	51,	Interval Between Onset and Death
Physicia /Medic	_	disease or condition resulting in death)	heert	or Jee	12		
Examin	-	Due to (or as a consequence	e ot):	disee.			July
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uted d ansit	i di di di di di di di di di di di di di	Sequentially list conditions, if any, leading to him such cause. Enter Underlying Cause (Disease or injury that initiated events	L)				years
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go / ou, ifficate be executed g physician and as the burial-transit	logical	d. It yearly	id emig				year 1
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ath cel ttendir	Maciology	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal deat		су		23d. Date of deli	ivery Day Year
the a	19	1   Yes 2   No 9   Unknown 9   Unknown	5 ☐ Other (specify) _				,
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ysicii is cer direct	a G		Outpatient 3 DOA	thor:	12	nce 6 □Other (Spec	cify)
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pital of urs af seral Dilled i	2		se dooth accurred at the	time, data and alone	and due to the sec	(a) and manner	
Hosp 24 ho Fund	legipo	29a. Certifier 1 Certifying Physician: To the best of my knowledge (Check only one) Medical Examines On the basis of examination and manner stated	4.6 1 12 12 14		4 4 14 47 4		
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	. N	29b. Signature and title of certifier	29c. Licer	nse number	296	d. Date signed (Mont	h, Day, Year)
F ≥ F ŏ		1 1 ms	Do	033420	0	11 - 5 -	57
0		30. Name and address of person w to empleted cause of death (Item 23a)	) (Type, Print)				***************************************
135		29b. Signature and title of certifier  30. Name and address of person who impleted cause of death (Item 23a)  31. Date filed (Month Day, Year)  NOV 0 9 2007	a Grance A	UE LOPI.	ata Md.	20141	
	State	31. Date filed (Month) Day, Year) 32. Rigistrar's Signature	1 1			The state of the s	
Reg	istra	NOV 0 9 2007 Server &	House				

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner

The law requires that the death certificate be executed burial-tran attending physician use as the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

21. Signature of Funeral Service Licel		22. Name and Address of Facility  108 William St.,	The Burbage Fun	
Part1. Enter the disease or comshock, or heart failure List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not one cause on each line.  a. Wtostetic Lob  Due to (or as a consequence of):		ac or respiratory arrest,	Approximate Interval Between
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacco use co	ntribute to the cause of death?  3 Probably 4 Unknow
			24a. Was an 24b autopsy performed? 1 ☐ Yes 2 ☐ No	Were autopsy findings available prior to completion of cause of death?     □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		eath (Check only one)  Home 5 Residence 6 □0	ther (Specify)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Tim Injury	of 28c. Injury at	28d. Describe how injury occi	urred
3 Suicide 6 Could not b 4 Homicide determined		street, factory, office	28f. Location (Street and Nur. City or Town, State)	mber or Rural Route Number,
	hysiclan: To the best of my knowledge, d miner: On the basis of examination and/o and manner stated.			
29h. Signature and title of certifier		29c. License number	29d. Date sign	ned (Month, Day, Year)

145 E Could street, Sole's buy, MD 2180

D0014314

29d. Date signed (Month, Day, Year)

november 8, 2007

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

PANPETP. KLUW, MO.

NOV 0 9 2007

Kan w FACT

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar		, ,	Cert	ificate of	Death		Reg	g. No.		
	*		1. Decedent's Neme (First, Middle, Las	- 1						Date of Death Month	Day	Yeer	3. Time of Death
	Physici /Medic		Elmer E	Sho	ockle	21/	Sr.			0 3	1 20	20.7	11:07 AM
}	Examin		4a. Facility Name (If not institution, give	street and number)		1	4b. City, Town, o	r Location o	f Death		4c. County	of Deeth	
L				ice at the	(In yrs. last bir	-	If Under 1 Year	If Under 2	4 Hrs.   Q I	Date of Birth	YV		nico (State or Foreign
ľ	Funeral Director		213-22-9930		78	Yrs.	Months Days	Hours	Min. Au	Date of Birth Month, Dey, 1 19 11,1	929	Cour	itry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loca	ation		····			1	0d. Inside City Limits
	Maryl f sho	ğ	MD Wicomic	0	Salis	bury	7				1 ☐ Yes 2½ No		
	r 28e	rec	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?
	th with	aiD	29033 Red Fox Dri	ve			21801	1			US	SA	
	ems erms	Funeral Director	11. Marital Status	12. Was Decedent Ed Armed Forces?		13. W	as Decedent of H Yes, specify Cuba	lispanic Orig an, Mexican	gin? (Specify , Puerto Rica	Yes or No- in, etc.)		ce - Americ ck, White,	
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28e-f show the Madical Examiner must be notified at	þ	1 Never Married 2X Married 3 Widowed 4 Divorced	1 Never Married 227 Married 112 Yes 2 No Arm			□Yes 2□xNo	Specify:			Specif	y: Bla	ack
7	be filed within 72 ho tal Hygiene. d other than "naturesent, the Modical	Completed	15. Decedent's Ed (Specify only highest gra		16a	(Give k	int's Usual Occup	during most	of working	10	6b. Kind of B	usiness/In	dustry
	within ane.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+			O NOT use retired	•	NT		24.		1
2	Hygi ther	ပိ	17. Father's Name (First, Middle, Last)			acen	sed Prac			rst, Middle, Ma		edica me)	
a		To Be	Elmer D. Shockley					Laura	E. Pa	rker			
Maryland 21	s 1 and 2 should be i Health and Menta flem 27 is marked other treumatic ev	F	19a. Informant's Name/Relationship (7	Type, Print)	198	. Mailing	Address (Street				City or Town	State, Zip	Code)
	ad 2 27 lg 7 tre		Thelma T. Shockley	y/wife	2	9033	Red Fox	k Driv	e, Sal	isbury	, MD 2	21801	
altimore,	of Hea of Hea f Item		20a. Method of Disposition	Demonstran Ctata	20b. Place o cemete	f Disposi	ition (Name of atory or other place	ce)	Date	20	0c. Location	· City or To	own, State
Ĕ	Pages nent of ant: If It ury or o		1 Asurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		Spring	hill	Memory	Gar 1	1/06/2	2007	Salish	ury,	MD
Balt	permit. Pag Department Important: b any injury o once.		21. Signature of Funeral Service Licen	Thurs		Le	Name and Addre	Vatson	Funer				
	变		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused t	the death. Do	not enter	18 West the mode of dyir	Rd ng, such as	Sallsk cardiac or re	spiratory arres	D 2180	,1	Approximate Interval Between
	Physician		Immediate Cause (Final	one cause on each line	4.	Ro	1 2	Size	est				Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	gorsequence	of):	al E	JIST	as _				
	Examiner		Conventially list conditions	b									
- 10	₽ ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (cr as a	Consequence	of):							
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		-4)						_	
60,	cate be executed physician and the burial-transit			Due to (or as a	consequence	Oi).						1	
68760	icate phys s the	Medical		, d									
ŏ	certifica nding ph use as t		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o							23d. Da	ate of delive	эгу
ň	death e atte d for	Physician/	in the past 12 months? 1 2 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic pregnancy Other (specify) _	y 			Me	onth	Day Year
<u>Т</u>	t the by the tache	hys	9 Unknown	9□ Unknown									
Records, F	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ρ	Part II. Other significant conditions of	ontributing to death but	t not resulting i	in the und	derlying cause giv	en in Part I.		23e. Did toba	~/	tribute to that	he cause of death? pably 4 DUnknown
S	law require as been si 2 should t	Completed								24a. Was an	24b.	Were auto	psy findings available
	The la	mo								autopsy perform 1 Yes 2	erd? El No	prior to co death? 1  Yes	mpletion of cause of
Vita		0	25. Was case referred to medical					26. Place	of Death (C	heck only one			7
	ysiclan: nis certifica director, p	To B	examiner?	Hospital:	t 2 ER/O	utpatient	3□ DOA Ott	ner: 4 🗆 Nu	rsing Home	5 🗆 Resider	nce 6 🗆 Oti	ner (Specif	<b>y</b> )
Division of	Attending Physiclan: or death. ector: After this certification of the funeral director.	Certification:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		Time of Injury	28c. Injui World M 1 [	yat rk? Yes 2∐1		Describe how	v injury occur	rred	
N	Attendi er death. ector: A by the fu	Iffica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, fa	arm, stre	et, factory, office		28f.	Location (Stre City or Town,		ber or Rura	al Route Number,
ā	tal or rs afte el Dij	Cer			(-,,								
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier Check only one) Certifying Ph	ysician: To the best of niner: On the basis of and manner stat	examination ar	e, death nd/or inve	occurred at the tile estigation, in my o	me, date and opinion, deat	d place, and th occurred a	due to the cau it the time, da	use(s) and m te and place,	anner as s and due to	tated. the cause(s)
	Withir To th	Me	29b. Signature and title of certifier	201			29c. Licens	se number		29	d. Date signe	d (Month,	Day, Year)
,	MHVM		10020	SOU, A	11		02	62	78		10-3	1-6	7
	1,30		30 Name and address of person who	completed cause of de	ath (Item 23a)	(Туре, Р	Print)	17	22 0	11	MD.	0 3	- 0.)
			31. Date filed (Mgryb, Pay, Year)	32 <b>R</b> egistra	r's Signatur	eve,	100 100	X1/3	3 4	3/11/2	ms.	110	01
	Sta Regista		31. Date filed (Month, Day, Year)	107 Sesera	- Signatur	200	roles			<i>)</i> '			

-08862		Please Type or Print in Black Indelible Ink. E	insure All Copies Are Legible.
oyd Marlin Sch		State of Maryland / Department of nea	th Reg. No. 2007 2770
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	2. Date of Death 2 3/Time of Death 1 3
ledical Exami	ner	Cloyd Marlin Schetrompf, II	Month Day Year 0653 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City,	Town, or Location of Death 4c. County of Death Washington
		vvastilitigioti cootiky ricopila.	der 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Funeral Director		Mon	the Days Hours Min. Country)
Director	ļ	215-94-5134 1XM 2 F 44 Yrs.	Jan.18,1963 Maryland
any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
* .	_	Maryland Washington William	sport 1 X Yes 2 No
Aaryland 28a-f show	Director		ip Code 10g. Citizen of What Country?
with the Maryland s 23a or 28a-f sho		36 West Salisbury Street	21795 USA
with h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Married Forces? 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Never Married 2 Married 17. Never Married 18. Was Decedent Ever in U.S.	dent of Hispanic Origin? ( Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
r deat or ite	핊	1 Yes 2 X No	2XX No specify: Specify: White
rs afte ural", mine	<u>ā</u>	or Dates:  15 Procedure Structure (Specify only highest grade completed) 16a Decedent's Usu	al Occupation (Give kind of work done 16b. Kind of Business/Industry
72 hou n "nai	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	vorking life. DO NOT use retired)
036 rithin and references	ompleted	11	Mason Construction  18.Mother's Name (First, Middle, Maiden Surname)
1215-0036 Id be filed within 72 hou dental Hygiene. narked other than "nat	ပ	17.1 atter 3 Marie (1 113), Middle, 2335)	Maybelle Phyllis Barger
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To Be	Cloyd Marlin Schetrompf  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Addre	ess (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	-	Maybelle Schetrompf - Mother 36 W. Sa	lisbury St. Williamsport, Maryland 21795
imore, MD 2 Pages 1 and 2 shoul nent of Health and N ant: If item 27 is n or other traumatic		20a. Method of Disposition (20b. Place of Dispos	ce)
nor Pages ent of not: If		Smithsburg C	rematory Nov.16,2007 Smithsburg, Maryland
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signatur of Funeral Privile Licen 4e	medifferent Home, P.A.
		23a. Part / Enter the disease, or complications that caused the death. Do not enter the modern than the disease are complications that caused the death.	. Conococheague St. Williamsport, MD 21795
Physician /Madical		failure. List only one cause on each line.	Between Onset and Death
caminer		Immeriate Cause (Final disease or condition resulting in death)  a. Diabetic ketoacidosis  Due to (or as a consequence of):	
		Sequentially list conditions, b	
	iner	if any, leading to immediate Due to (or as a consequence of):	
	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
cecuted n and - transit	l <del>≂</del> l	v	
), be exe sician			7 TT 23d. Date of delivery
Box 68760, e death certificate be exe the attending physician a ed for use as the burial -	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de	Month Day Year
OX 68 eath certi	icial	past 12 months?  4 Pregnant at time of death 5 Other (3)	Specify)
BO) le death the att	hys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underly	ving cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
that the ned by detack	by P		1 Yes 2 No 3 Probably 4 ✓ Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Astending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and complexive filled in which funeral infrared process as the burial - transitional and a signed for use as the burial - transition and a signed for use as the burial - transition and a signed for use as the burial - transition and a signed for use as the burial - transition are a signed by the attention of the signed by the attention of the signed by the attention of the signed by the attention of the signed by the attention of the signed by the attention of the signed by the attention of the signed by the attention of the signed by the signed by the attention of the signed by the attention of the signed by the attention of the signed by the attention of the signed by the attention of the signed by the attention of the signed by the attention of the signed by the attention of the signed by the signed by the attention of the signed by the sinterval by the signed by the signed by the signed by the signed b	te		24a. Was an 24b. Were autopsy findings available
COFC law re has be 2 sho	Completed		autopsy prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
Rec The ficate	5		1 ✓ Yes 2 No 1 ✓ Yes 2 No 26.Place of Death (Check only one)
ital sician:	8	25. Was case referred to medical examiner?  Hospital: Inpatient 2 FR/Outpatient 3	DOA Other Nursing Home 5 Residence 6 Other:
of V g Phy: fter thi	<u>P</u>	27 Manner of Death 28a Date of Injury 28b. Time of Injury	28c. Injury at Work? 28d. Describe how injury occurred
OD on ending sath.	Certification:	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No
VISI or Att fler de Directe	<u> </u>	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factor 3 Suicide 6 Could not be	ctory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Dipital ours a neral I	1 5	4 Homicide determined (Specify)	and the second of the second o
n 24 h	g E		it the time, date and place, and due to the cause(s) and manner as stated.  In my opinion, death occurred at the time, date and place, and due to the cause(s)
To the within To the	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
		And Rockell non	O.C.M.E. November 16, 2007
		30. Name and address of person who completed cause of death (Item 23a)	
0-HC		Pamela E. Southall, MD Assistant Medical Examiner 111 P	enn Street, Baltimore, MD 21201
	Stat		
Reg	sira	NOV 1 9 2007	8. · · · · · · · · · · · · · · · · · · ·

DHMH 17 Rev 1/2001 OCME 2006

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State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Daniel Watkins STRAUB November 13, 2007 1205 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington 832 Chestnut Street Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 82 212-14-6812 Director May 1, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 ie marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Madical Examiner must be notified al 1 X Yes 2 ☐ No Maryland Washington Hagerstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 832 Chestnut Street 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 TYes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: þ 3 ₩ Widowed 4 Divorced Year or Dates: WW II white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. In and Menta! Hygiene. 7 ie marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) packed cement cement company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George William Straub Erma Viola Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an ant: if itam 27 ie Linda Reese - daughter 22 Miss Staci Drive, Martinsburg, WV 25404 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if eny injury or page. St. Paul's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/17/07 Clear Spring, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses L'Vestal 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes of Vital No To the Hospitel or Attending Physicien: To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 30 No မှ 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Division Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death investigation 6 □Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) No Vember 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-5+1 Hagerstown, MD 21740 OM, me 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NUA

**ORIGINAL** 

	For State Registrar	cei	Mment of Health and tificate of Death	Reg. N	
Physician /Medical	1. Decedent's Name (First, Middle, Last)  James Floyd Strip	ne			3. Time of Death  Year  99  72:30 PM
Examiner	4a. Facility Name (If not institution, give stree  Western Maryland Hos  5. Social Security Number 6. Sex	t and number)	4b. City, Town, or Location of Dea Hagerstown If Under 1 Year   If Under 24 Hrs	th 4	c. County of Death  ashington
Director	215-20-7706  Usual Residence of Decedent  10a. State  10b. County	2 F 81 Yrs.	Months Days Hours Min	. (Month, Day, Yea	1926 Maryland
death with the Maryland ms 23e or 28e-f ehow rmust be notified at meral Director	Maryland Washington  10e. Street and Number	Hagerstown		10g. C	1  Yes 2 No
6 Site of the matter of the ma	A	Was Decedent Ever in U.S. 13. \ Armed Forces?	21742 Vas Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	S • A •  14. Race - American Indian, Black, White, etc.
5-0036 72 hours after naturel; or ite lical Examina	3 ☐ Widowed 4 ☐ Divorced Y	Yes 2 No t Yes, Give Year or Dates:	Yes 2 No Specify:	16h	Specify: White Kind of Business/Industry
		College (1-4or 5+)  5+  Judge		orking (	Government
laryland 212. 2 should be illed within and Mental Hygiene. Is marked other then aumatic event, the Me	17. Father's Name (First, Middle, Last) Floyd Strine  19a. Informant's Name/Relationship (Type, F	Print) 10h Maille	_	me (First, Middle, Maide cene Hull Jural Boute Number City	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Mer Important: If tem 27 is marks any injury or other traumatic once.	Virginia M. Strine  20a. Method of Disposition  1 Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)  21. Signature Funers Serve License	Wife 1971 val from State 20b. Place of Dispo- cemetery, crem Smithsbur	Meadowbrook Rd.  sition (Name of natory or other place)  cg Crematory 11/1	Hajerstown Date 20c.	
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ons that caused the death. Do not ent-	001 Pennsylvania er the mode of dying, such as cardia TIENS OF H PNEUMON,	Ave. Hagers or respiratory arrest,	stown Maryland 2174 Approximate
Attending Physician: The law requires that the death certificate be executed death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit filtcation; To Be Completed by Physician/Medical Examin	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Cords, P. wrequires that the been signed by should be deta	Part II. Other significant conditions contribu	iting to death but not resulting in the ur	derlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?  2 No 3 Probably 4 Umknown
Vital Records, sicien: The law requires to certificate has been signer rector, page 2 should be to Be Completed by	25. Was case referred to medical			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
ision of Vita trending Physician: death. ttor: After this certific the funeral director, to Be (	examine f?	Ba. Date of Injury (Month, Day Year)  2Bb. Time of Injury Injury	3 DOA Other: 4 Nursing 28c. Injury at Work?	Home 5 Residence	ury occurred
Division of tall or attending F attended to attending F attended: After ed in by the funer: Certification;	2 Xaccident investigation 3 Suicide 6 Could not be determined	Be. Place of Injury: At home, farm, street building, etc. (Specify)  HV		28f. Location (Street a	STATILS HOME, GENARD NUMBER, GENARD NUMBER OF AUTO POLITICAL PRINCIPLE PROPERTY OF HELPS
Divisor To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by it Medical Certific	(Check only 2 Medical Examiner: (	n: To the best of my knowledge, death On the basis of examination and/or invand manner stated.	occurred at the time, date and place estigation, in my opinion, death occurred.  29c. License number	e, and due to the cause( urred at the time, date at	s) and manner as stated
P W P O	30. Name and address of person who comple	ted cause of death (Item 23a) (Tyre	D0064911	1	1/12/-7
OH-4+1	Muhammed Abdulah		<sup>rint)</sup> 1500 Pennsyl	vania Avenu	e

			For State	State of Ma	ıryland					-	_	000	7	27	000
			1 - State Registrar			Cei	tificate of	Death			Reg. No.	201	) 7	37	800
	Physici	an	Decedent's Name (First, Middle, Last	1 411/2	<	- L.1	4		2.	Date of De Month	ath Day	/ Y	'ear	3. Time of	
	/Medic	cal	4a. Facility Name (If not institution, give	LATFICE !	1	MITH	4b. City, Town, or	r Location	of Death	Nov	) 40	County of	26.7	11:1	5P M
	Examir	er	Wastins by Con		11		HAS ERS	TOWN	)		ı	105 Hin	t	)	
- back	Funeral			6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24						Date of Birt	th		. Birthpla	ace (State o	or Foreign
	Director		216-22-8202	]M 21☑F	80	0 Yrs.	Months Days	Hours	Min.	(Month, Da ugust		1927	Count	y) : Virg	inia
	pu ,	1	Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation							d. Inside Ci	
	anyla shov	7			•										2 □ No
	the M	Director	Maryland Washing	gton	Над	gersto	10f. Zip Code				10a Citi	zen of Wh	at Count	n/?	
	with a or			G = 4	000						· ·		at Oodin	.,.	
	hs 23	Funeral	11 West Baltimore	12. Was Decedent E		13.1	21740 Was Decedent of H f Yes, specify Cuba	lispanic O	rigin? (Specif	y Yes or No		SA 14. Race -			
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notitled at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎛 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		fYes, specify Cuba 1∐Yes 2⊠ No	an, Mexica Specify		an, etc.)		Black, Specify:	White, e		
Ö	72 hol	Completed	15. Decedent's Edu (Specify only highest grad	ication	Ţ	16a. Dece	ient's Usual Occup	ation	st of working	Į.	16b. Ki	ind of Busi	ness/Ind	ustry	
218	filed within 7 I Hygiene. other than "r ent, the Med	nple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. I	kind of work done OO NOT use retired	d)	st of Working						
21	ed wi lygier ner th		12			Cashi	er	10 Math	anda blanca //	Timo & Baladadia		od Se		ce	
Maryland	be fill	Be	17. Father's Name (First, Middle, Last)	-L					ier's Name <i>(F</i> aude Be			,			
Ĕ	should I ind Men i marker umatic	ို	Lafayette Herbaug			10h Mailir	ng Address (Street						ata Zin	Code)	
Ma	1 and 2 should be filed Health and Mental Hygi em 27 Is marked other ther traumatic event, ti		Nelson P. Smith/S				6 Brookf				-			•	
<b>ઈ</b>	Health tem 27		20a. Method of Disposition	5011	20b. Pla	ce of Dispo	sition (Name of	1	Dat			cation - Ci			
υOπ	Pages Tent of It Int: If Ite	i	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,		1		natorý or other plac en Cemete	1	11/16	/2007	Цас	orato		Marri 1	and
Baltimore,	in je art if		21. Signature of Juneral Service Licens		Kes		2. Name and Addre		lity Rest	Havei	n Fu	neral	Cha	<u>maryr</u> pel	anu
m	Depa Impo any ii	1	1 2/				601 Penns							-	742
	FERT		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lin	the death.	Do not ent	er the mode of dyir	ng, such a	s cardiac or r	espiratory a	rrest,			Approximate	tween
	Physician		Immediate Cause (Final disease or condition	APIOST	profession and the same	Nemi								Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):									
	LXammer	_	Sequentially list conditions,	b Due to (or as a		noo of:									
	ted isit	je l	Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	Due to (or as a	conseque	nice oi).									
	xecul al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a conseque	ence of):									
68760,	ficate be executed physician and the burial-transit			d											
89	ificate g phy as the	edical		·											
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and hate 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ☑ No 9 □ Unknown	23c. If yes, outcome   1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal d	leath 3	Ectopic pregnancy Other (specify)	у				23d. Date Mont		-	Year
	res that signed by be deta		Part II. Other significant conditions co	ntributing to death bu	it not result	ing in the u	nderlying cause giv	en in Part	I.	23e. Did t	tobacco	use contrib	ute to th	e cause of	death?
Vital Records,	quires n sign	d by	SEVERE ANOMIA	Ove to D	plosti	C. A!	IEMIX			1 🗆	Yes 3	Ø No 3	☐ Proba	ably 4 🗌	Unknown
တ္တ	aw requi	Completed	ACUTE RONA POILVA	e on ctin	DINIC	FION	ey Disep	50		24a. Was		24b. W	ere autor	osy findings	available
æ	The lay	mo du	Historia of stold	F. L. Usta	5 SLT	S15 0-	5/ pocer	0	_	auto perfo 1□ Yes	psy ormed? 22 No	de	ath? .	npletion of d M∕ No	ause of
ta		Be C	25. Was case referred to medical		ا (عادی	(	TO COU.		e of Death (		-	, , , ,	- 1		
>	<u>≈</u> .e =	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatie	nt 2□E	R/Outpatier	t 3□ DOA Oth	ier: 4□N	lursing Home	5 ☐ Resi	dence	6 □Other	(Specify	')	
n or	ng ftel		27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	8b. Time o	Wor	<b>1</b> k?		d. Describe	how inju	ry occurred	d		
Sio	Attending r death. ector: Affer by the fune	catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2							
Division	l or Attencater death Director:	Certification:	4 Homicide determined	28e. Place of inju- building, etc		ie, farm, str	eet, factory, office		28	Location ( City or To			or Rura	l Route Nun	nber,
	pital		29a. Certifier Certifying Phy	sician: To the best o	of my knowl	ledne deat	n occurred at the ti	me date a	and place, an	d due to the	cause(s	) and man	ner as st	ated	
	24 hc 24 hc Fun etely	Medical		iner: On the basis of and manner sta	examination										s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f.	Me	29b. Signature and title of confiler				29c. Licens	e number			29d. Da	te signed (	(Month, I	Day, Year)	
			1 mstam				2002	530	7/		11/	12/2	00	7	
	: 1		30. Name and address of person who c	ompleted cause of de	eath (Item 2	23a) (Type,	Print)	10.000	1	11		1 1	-	1	
8	H- 2		MARE BARON MO, to	5p.401.51.0f	100	Wast.	inston (	OUNTE	Mord	61,2	51 E.	anlie!	am S	1. Mx	1825 JOW
	Sta Regist		MARL BARON MD, from 31. Date filed (Month, Day, Year)  NOV 1 3 20	07 32. pegistra	ar's Signatu	re	Print)	l	1	,					

	pairillore, iviaryland z1z13-0036		i.	
Ph	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	ä		
y: Me		Fi Di	-	
sic ed	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	un re	Ex	
cia ic	any injury or other traumatic event, the Medical Examiner must be notified at	ei	aı	
ırı al	once	o	n	•

Examine

10 Regist

Division or Vital Records, P.O. Box 68760,

	= State Registrar			Cei	rtificate o	f Death		Reg. No. 2	007	3780	
	1. Decedent's Name (First, Midd	lle, Last)					2. Date of De		V	3. Time of Death	
ian cal	JOSEPH	EDWARD SN	YDER, JI	₹.			Month NO	v 4 20	07	1:10 P M	
	4a. Facility Name (If not institution	on, give street and n	umber)		4b. City, Town	or Location of De	ath	4c. Cc	ounty of Death		
	NATIONAL NAVA	L MEDICAL	CENTER						ONTGOM	ERY	
	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea			rth	9. Birth	place (State or Foreign	
	215-38-9761	1 🛣 M 2 🗆 F	8:	3 Yrs.	Months Day	s Hours Mi			24 Nort	h Dakota	
1 -	Usual Residence of Decedent	1					1000. 2	J, -/-	-11020	II DUNOLU	
1. 1	10a. State 10b. County	/	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits V	
혅	Virginia Fairí	ax	Mc.	Lean						1 ☐ Yes 2 No	
Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cou	ntry?	
	1224 Perry Will	iam Drive			22101			U.S.A			
1 5	11. Marital Status	12. Was De	cedent Ever in U.	S. 13. \			(Specify Yes or No erto Rican, etc.)		Race - Americ	can Indian,	
	1 ☐ Never Married 2 🛣 Mai		2 No 194	/. /.	37		erto Hican, etc.)		Black, White,	etc.	
2	3 Widowed 4 Divorce	If Yes, G	ive Dates: 19	79	I□Yes 2☐N	Specify:		St	ecity:	ite	
Completed	15. Decede	nt's Education		16a. Deced	lent's Usual Occ	upation		16b. Kind	of Business/In		
ple	(Specify only higher Elementary/Secondary (0-12)	est grade completed	) (1-4or 5+)	(Give life. L	kind of work dor DO NOT use reti	e during most of w red)	orking				
e e	Liementary/Secondary (0-12)	5+		Rear	Admira1			Unite	d State	es Navy	
BeC	17. Father's Name (First, Middle	, Last)				18. Mother's N	ame (First, Middle			-B Mavy	
0 0	Joseph Edward	Snyder. S	r			Nellie	T				
1-	19a. Informant's Name/Relation:		L •	19b Mailin	a Address (Stre		Lewis Rural Route Numb	ner City or T	own State 7ii	Code)	
	Mary Louise Sn		Fρ								
-	20a. Method of Disposition	, uci wii			sition (Name of	viiiam l	Drive, Mo		VA 221 tion - City or To		
	1 Burial /2 Deremation	3 □Renyoval from	2 51010	emetery, crer	natory or other p			200. LOCA	non - City or 1	own, state	
	4 □ Donation / 5 □ Other (		Cr	ematio	King n Servio	es   11/	08/2007	Chant	:illy,	Virginia	
	21. Signature of Funeral Service	Licensee		22   M	Name and Add	ress of Facility Ling Fune	ral Home	. TNC			
	1/20/2	110		1	71 W. Ma	ple Ave.	ral Home Vienna,	Virgi	nia 22	180	
	23a. Part1. Enter the disease, or of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cause on each line.									Approximate Interval Between	
	Immediate Cause (Final			י די די	DARDIZ CLAN	CED				Onset and Death	
	disease or condition resulting in death)		TASTATIO		LAIE CAN	CER			-		
			(0. 40 4 00004								
늅	Sequentially list conditions, if any, leading to immediate										
i.E	Cause (Disease or injury that initiated events c										
Examiner	that initiated events c										
dic	d										
/Medical	IF FEMALE: 23b Was decodent graphers 23c. If yes, outcome pf pregnancy										
	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Feta	Ideath 3□	Ectopic pregnar	су		230	<ol> <li>Date of deliver</li> <li>Month</li> </ol>	ery Day Year	
Sic	1 ☐ Yes 2 ☐ No	4⊟Preg 9⊟Unki	jnant at time of d nown	eath 5□	Other (specify)				WOTH	Day Teal	
Physiciar	9 Unknown						1				
by F	Part II. Other significant condit	ions contributing to	death but not resi	ulting in the ur	nderlying cause (	iven in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?	
							_ 1 🗆	Yes 2XI	No 3□ Prol	oably 4 □Unknow	
Completed							24a. Was	an 2	24b. Were auto	ppsy findings available	
Ē.			_			· · · · · · · · · · · · · · · · · · ·	- auto			mpletion of cause of	
	er 111						1□ Yes	2 XNo	1 ☐ Yes	2□ No	
0	25. Was case referred to medica examiner?	Hospital:			10	26. Place of D	eath (Check only	one)			
	1 Yes 2 No	<u> </u>		ER/Outpatien	I SLI DOA	4 ☐ Nursing	Home 5 ☐ Res			fy)	
은	27. Manner of Death 1 □ Natural 5 □ Pendii	28a. Date (Mo		28b. Time of Injury	28c. in	ury at ork?	28d. Describe	how injury o	ccurred		
F 18	1 Natural 5 Pending (Month, Day Year) Injury Work?										
$\vdash$	2 Accident investigation  3 Suicide 6 Could not be determined determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Num.								lumber or Rura	al Route Number,	
$\vdash$	3 Suicide 6 Could	nined Zoe. Flac	4 Homicide determined building, etc. (Specify)								
$\vdash$	3 ☐ Suicide 6 ☐ Could	nined Zoe. Flac		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man							
Certification: T	3   Suicide 6   Could determ 4   Homicide 29a. Certifier 1   X Certifyi	nined 2009. Place build	e best of my kno	wledge, death	occurred at the	time, date and pla	ce, and due to the	cause(s) an	d manner as s	tated.	
Certification: T	3   Suicide 6   Could determ 4   Homicide 29a. Certifier 1   X Certifyi	nined 200. Place built	e best of my kno basis of examina nner stated.	wledge, death tion and/or inv	occurred at the restigation, in my	time, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) an , date and pl	d manner as s ace, and due t	stated. o the cause(s)	
ledical Certification: T	3 Suicide 4 Homicide  6 Could determ  29a. Certifier (Check only 2 Medical	ng Physician: To the and ma	basis of examina	wledge, death tion and/or inv	estigation, in my	time, date and pla opinion, death oc nse number	ce, and due to the curred at the time	, date and pl	d manner as s ace, and due t igned (Month,	o the cause(s)	
ledical Certification: T	3 Suicide 4 Homicide  6 Could detern  29a. Certifier (Check only one)  1 Certifyi 2 Medical	ng Physician: To the Examiner: On the and mai	basis of examina	wledge, death tion and/or inv	zestigation, in my	opinion, death oc	ce, and due to the courred at the time	, date and pl	igned (Month,	o the cause(s)	
Medical Certification: T	3 Suicide 4 Homicide  6 Could detern  29a. Certifier (Check only one)  29b. Signature and title of certifier	ng Physician: To the Examiner: On the and mai	basis of examina nner stated.	tion and/or inv	/estigation, in my	opinion, death oc nse number	curred at the time	, date and pl	igned (Month,	o the cause(s)	
Medical Certification: T	3 Suicide 4 Homicide  6 Could detern  29a. Certifier (Check only one)  1 Certifyi 2 Medical	ng Physician: To the Examiner: On the and mai	basis of examina nner stated.	tion and/or inv	29c. Licer MD 3	opinion, death och nse number 3162 ATTONAL	NAVAL ME	29d. Date s	igned (Month,	o the cause(s)	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Month 1 Decedent's Name (First, Middle, Last) Day Physician 2007 NOVEMBER 5 4:51 AM EMILY MAYE SHAULIS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S GRASONVILLE 121 QUINN ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JULY 31, 1 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours PENNSYLVANIA 1 ☐ M 2 🕱 F 1923 181-14-9453 84 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Funeral Directo GRASONVILLE MARYLAND QUEEN ANNE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe UNITED STATES 21638 121 QUINN ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Yes 2 No Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: WHITE Baltimore, Maryland 21215-0020 Š 3 Widowed 4 □ Divorced ri Yes, Give Year or Dates: 1945-1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) STATE OF MARYLAND College (1-4or 5+) Elementary/Secondary (0-12) COMPTROLLER'S OFFICE INCOME TAX CLERK of the and Mental Hygie 27 is marked other the traumstic event, the 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ELLA HUDEC SAMUEL REESE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a important: If itam 27 is any injury or other tra WILLIAM FRANKLIN SHAULIS, JR./SON 524 BROWNSVILLE ROAD, CENTREVILLE, MARYLAND 21617 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition NOVEMBER 9 CROWNSVILLE VETERANS 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE, MARYLAND CEMETERY 21. Sign ... e of unetal Service Licensee 22. Name and Address of Facilit FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Fart1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one crute on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Stage Examiner Chronic physician and the bunal-transit or Attending Physician: The law requires that the death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) use as the 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The law require within 24 hours aftar death.

To the Funeral Director: Aftar this cartificate has been sit completaly filled in by the funeral director, page 2 should it. Be Completed 21.20No 1 □ Yes 2 □ No TL Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edicai 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of corti NOVEMBER 5, 2007 D38158 SP

Registrar **DHMH 16 Rev 6/95** 

State

10

LTSA A.

2003 MEDICAL PARKWAY, SUITE 100, ANNAPOLIS, MARYLAND 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registrar's Signature

DIMARZIO, M.D.,

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 04 2007 **Physician** 9:30 AMM Warren V. Strader /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Sykesville Fairhaven If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Days Min. Hours 8/14/1922 1,□M 2□F Gregory, WV 85 233-30-5349 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show aţ 1 ☐ Yes 2 No Sykesville r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified Director Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 7200 Third Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? ↑CX es 2 □ No If Yes, Give Year or Dates:1942-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Specify: white Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinery supply Office manager 12 should be filed whand Mental Hygien is marked other the permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winnie Dell Williams Strader Willie Harrison Strader ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 111 Overhill Rd., Baltimore, MD Patricia Reed (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 **№** Burial 2 ☐ Cremation 3 ☐ Removal from State Morgan Chapel Cemetery 11/8/07 Woodbine, MD 4 □ Donation 5 □ Other (Specify) Signature of Function Service Licensee <sup>22</sup>Name and Address of Facility Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final obstructive years Physician Severe disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** lung interstitial if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as the attending p 23c. if yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No ed by the a 9 I Unknown cate has been signed by , page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) Be ( 25. Was case referred to medical examiner? director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2**X**, No 1 🔲 Yes Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After (Month, Day Year) Injury 1 Alatural 5 Pending investigation n 24 hours after death.

ne Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title pretifier November 5 2007 D34849 AVIXOI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Eldersburg Libert 1645 MD William lan 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Edna Lee Shriver 11 2007 8:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Hours 1 ☐ M 2 🔀 F 238-46-2640 76 2/14/1931 Director North Carolina Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2284 Ballard Way 21042 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace · American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White ģ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 02 Residence les 1 and 2 should be filed vor Health and Mental Hygie of Health and Mental Hygie fitem 27 is marked other to other traumatic event, the other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilmer Cole Minnie Dillon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Amos Ernest Shriver, Jr. - son 2284 Ballard Way Ellicott City, Maryland 21042 ce of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State Evergreen Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/6/2007 Gettysburg, Pennsylvania 22. Name and Address of Facility Eline Funeral Home, 934 South 21. Signature of Funeral Service Licensee In all M01490 Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANOXIC weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sstruc Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-tra Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE. 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a o. 9□Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 2 No Vital 1□ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 10 ) 1 Yes 2 No 1 TI Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ō funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Division or Attending Injury 1 Natural 5 ☐ Pending investigation 1∏Yes 2∏No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 29a, Certifier Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

HELL 3

Ovenber

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 05

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

**ORIGINAL** 

6701

32. gistrar's Signature

5 205

29d. Date signed (Month, Day, Year)

Bolto, Md ZIZOX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Wayne Mason Thomas 11/06/2007 4:40 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Chever1v Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 11X M 2 □ F Director 61 4/06/1946 213-44-4198 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 √ Yes 2 No Director MD Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2415 59th Place 20785 death v Funeral U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event. the Natural of the process. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:66-68 1 ☐ Yes 2 🖾 No þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Construction Worker Iron Workers Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Thomas Lena Pepper Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kirk Thomas - Son 8701 Jarwood Rd., Rosedale MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metropolitan Crematory 11/8/07 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign vire of uneral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home Hyattsville, MD 20781 repa M01491 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of) **Examiner** Coronary artery bypass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Caroted endarterectomy Due to (or as a consequence of): physician Hypertension Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Ethanol abuse 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has blirector, page 2 s autopsy performed?

1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖾 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours af • Funerai D etely filled i

To the within 2

Division or Vital Records, P.O. Box 68760

State Registrar

Medical

29a. Certifier

X11 Naficy, MD 3001 Hospital Dr., Cheverly, MD 31. Date filed (Month, Day Year)

0 8 2007

Mohammad

dress of person who completed cause of death (Item 23a) (Type, Print)

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and place, and due to the cause(s) and place, and due to the cause(s).

29c. License number

D.14182

29d. Date signed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

8603 Binghampton Place

Donna Tucker

5. Social Security Number

 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1 □ M 2 1 F Hours GlenRidge, 68 06/25/1939 N.I 214-36-3688 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 'natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8603 Binghampton Place 20772 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 22€ No White Specify: þ 3 ☐ Widowed 4 A Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked oth any Injury or other traumatic event Be Donald W. Ludovici Virginia A. Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Lester - Daughter 4912 42nd Place, Hyattsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/8/2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Zamera Gasch's Funeral Home, P.A. Hyattsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Solot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma of Lungs **Physician** /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been sign page 2 should be Hypercholesterolemia 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2⊠ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) this 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident Director 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D Hospitai 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43276 11/8/07 ress of person who completed cause of death (Item 23a) (Type, Print) Imelda P. Miranda, MD 7611 S. Osborne Rd., Ste 106, Upper Marlboro, MD 20772 31. Date filed (Month, Day, Ye NOV 0 8 200 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

7. Age (In yrs. last birthday,

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Upper Marlboro

2. Date of Death

Day

4c. County of Death

Prince George's

11/06/2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 8:55 a.m. 12, 2007 Delores November Thomas /Medical Ann 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's <u>Leonardtown</u> Birthplace (State or Foreign Country) If Unde 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 M 2 X F Director 11-01-1942 220-40-2568 65 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland St. Mary's Compton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 23a 22263 Newtowne Neck Road 20627 United States death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify **Black** Specify: ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Service Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Horace Melvin Robinson Mary Florine Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Corey Kane / Son 6305 Hillmar Drive, District Heights, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important; If ite any injury or ot tXXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gdn. 11-17-2007 Leonardtown, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Due to ( A s a consequence of): MINUTES disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buris Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed cate has been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforme within 24 hours after death. To the Funeral Director; After this certificate or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 🗌 Yes 2 ER/Outpatient 3 □ DOA 1 Inpatient 2 HOMAS, 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: (Month, Day Year) 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

Derores

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

SVOBODA

2007

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egistrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)

POINT LOOKOUT ROAD, LEONARDOWN, MD 20650 25500

00062937

29d. Date signed (Month, Day, Year)

NOVEMBER 12, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 200<sup>Year</sup> **Physician** NOVEMBER 9:54 A M THOMAS SUSIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 1926 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 □ M 2 🖵 F Yrs. 81 SEPTEMBER 16 MARYLAND 579-36-6415 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director PRINCE GEORGE'S CAPITOL HEIGHTS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6717 SEAT PLEASANT DRIVE 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 ☐ No 'natural", or If Yes, Give Year or Dates: Specify þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) DOMESTIC PRIVATE permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Item 27 Is marked oth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUCY FREDERICK FORBES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 6717 SEAT PLEASANT DRIVE CAPITOL HEIGHTS, MARYLAND LOUISE SAUNDERS/DAUGHTER Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State RESURRECTION CEMETERY 11/13/2007 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 nu 23a. Part1. Enter the disea , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) CARDIAC ARRHYTHMIA /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the SIS IF FEMALE use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ē in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No page 2 s autopsy performed? Yes 20 No Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 X ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 1X Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a

To the Funeral I 29a, Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical соmpletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type-Print) -Drive

State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day You NOV 0 9 2007

32. Registrar's Sign tur

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 8:50 рм October 29 2007 Carolyn Anne Tuchis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gaithersburg Montgomery 28 Pavilion Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 K F 224-40-0057 Virginia November 22,1932 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 28 Pavilion Drive 20878 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Heatth and Mental Hygiene Important: If item 27 Is marked other the any injury or other traumatic event, the once. Pathology Researcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Tuchis Alice Turner မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianne Wreglesworth - Cousin 27 Downing Street, Toronto, Ontario, Canada M9B1E9 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11/13/2007 Brentwood, Maryland Ft. Lincoln Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician DmC/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissause or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the attending p for use as 35 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 page death? 1 □ Yes certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA ٩ After this funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury To the Funeral Director: Att 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physiciant to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of centifier 1000428 pmE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 210/ metical Park Dr ILA N BRECHER MDOME S(Ver Spring) mD 209 31. Date filed (Month. Day. Year) 32 Paristrar's Signature 31. Date filed (Month, D. Pagistrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

		1	State	State of Maryland	/ Depa	rtment of F	lealth and M Death		iene 2007	37810
			Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
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	/Medic	ai		elma Trice		4h City Town o	r Location of Death	Novembe	4c. County of Deat	
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- 12			Caroline Nursing He	ome, Inc. 7. Age (In yrs. las	+ highday)	Dento If Under 1 Year		8. Date of Birth	9. Birt	hplace (State or Foreign untry)
	Funeral		5. Social Security Number 6. Sex	M SETTE	Yrs.	Months Days	Hours Min.	(Month, Day, April 1	Year) Co 5.1914 M	aryland
q lag	Director	1	214-07-7930 Usual Residence of Decedent	93				npour 1	7,1717 11	wigewar.
	and *	-	10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
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	he N	Directo	Maryland Carolin	e 9	neer os	10f. Zip Code		1	0g. Citizen of What Co	untry?
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	s 236	Funeral	25325 Sandy Point	Road. 2. Was Decedent Ever in U.S.	13. V	2163 Vas Decedent of h	dispanic Origin? (Sc	ecify Yes or No-	14. Race - Ame	ncan Indian,
	er de Item	nu	11. Marital Status  1 Never Married 2 Married	Armed Forces?	H	Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
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2-0036	hour tural	pa	15. Decedent's Educ		16a. Deced	ent's Usual Occu	pation		16b. Kind of Business	
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2	tied within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23e or 28e-f show ant, the Machest Examiner must be motified at	Be Completed	17. Father's Name (First, Middle, Last)		OEMINS		18. Mother's Nam	e (First, Middle, I	Maiden Sumame)	
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mantal Hygiene. Importent: if item 27 is marked other than "natural", or any injury or other treumatic event, the Madical Examinance.	으	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Stree			r, City or Town, State, .	Zip Code)
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	1 and Health Im 27	1	Benjamin C. Trice 20a. Method of Disposition	120b. Pla	ice of Dispo	sition (Name of		Date	20c. Location - City or	Town, State
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ш_	20E = 9		Jana gra	11000	_ 1	South.	Second St	reet, Dei	nton, Mary	Approximate
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			30. Name and address of person who c	ompleted cause of death (Item	23a) (Type	. Print)	CA Do	stav	11/14/0	79
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burial-transit	mine	Sequentially list con if any, leading to importance. Enter Under Cause (Disease or ithat initiated events	flying ¬	<	4	11	channe							years
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**ORIGINAL** 

32. Registrage Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 0041 M William Theodore Torney, Jr. Nov 4, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X M 2 □ F 579-50-5393 Wash., D.C. Director 66 Nov 11, 1940 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notifiled at 1 ☐ Yes 2 No Directo Clinton MD Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 U.S.A. 6411 Willow Way Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify Specify: à Black 3 ☐ Widowed 4 ■ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) Private Club Stewart 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fannie Mae Johnson William T. Torney, Sr. ္က 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Health a 3200 Norshire Terrace Bowie, MD 20716 Donica Lawrence /Daughter permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 11/10/07 Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service Licens 22. Name and Address of Facility Sewell Sewell Funeral Home Bladys a. 1451 Dares Beach Road Prince Frederick, MD 20678 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed and for use as the burial-trar Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign. be o Completed by DIABETES 2 No 3 Probably 4 Unknown 1 Yes HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has S page certificate 1□ Yes 20 or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one director Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

Baltimore, Maryland 21215-0036

or Vital Records, P.O. Box 68760,

State Registrar

29b. Signature and title of certifier

TERRY JODRIE, MD

7503 SURRATTS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROAD,

29c. License number

D40324

CLINTON.

29d. Date signed (Month, Day, Year)

MARYLAND 20735

NOVEMBER 5, 2007

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

show

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r than "natural", or the Medical Examin

Director

Funeral

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Completed

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Certification:

Medical

31. Date filed (Month, Day, Year)

NOV 09

State Registrar

20602

Nirmaladevi Jayanthan, M.D. 3328 Old Washington Rd. Waldorf, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Byron Sheldon Ta	-	r St - For State	tate of Maryla	and / Depa	rtment of tificate of	Health	and	Menta	l Hygi		N	201	7	3.	781	F
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Physiciar Medical Examin	Byron Sheldon Taylor								Month Day Year October 27, 2007			0330 hrs				
		4a. Facility Name (if not institution	on, give street and nu	ımber)	4	b. City, To			Death			unty of Dea cester	th			l
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15-0 filed v I Hygi d other		17. Father's Name (First, Middl Alfred C. Tay					'			M. Col						۱
e, MD 21215-0036  I and 2 should be filed within 72 hours after Health and Mental Hygiene. Titem 27 is marked other than "natural", or traumatic event, the Medical Examiner.	o Be	19a. Informant's Name/Relation			19b. Mailin	g Address	(Street	and Num	ber or Ru	ral Route Nur	nber, City	or Town, St	ate, Zi	Code)		1
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at ouce.		20a. Method of Disposition	an 3 Romovol	20b.	Place of Dispos crematory or of	sition (Nam ther place)	e of cem	- 1		Date	1	ation - City				
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Physician /Medical		failure. List only one caus	se on each line.											Between 0 Dea		1
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Division tall or Attendir rs after death.  "al Director: A led in by the fu	<u>:</u>	3 Suicide 6 C	could not be 28e. P	ace of Injury - At	home, farm, str	reet, factory	, office I	ouilding, e	tc.	28f. Location or Town		d Number o	or Rura	Route Nu	imber, Ci	у
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Division of To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29b. Signature and title of cer	and manne	er stated.				se numbe				ate signed			er)	_
	-	M/	A) - P/c	0.11			O.C.	M.E.			Octo	ber 28, 2	2007			
Qu		30. Name and ad ess of per	rson who completed o	ause of death (Ite	em 23a)											
La		Margarita Korell M	<ol><li>Assistant N</li></ol>	1edical Exam	iner 111	Penn St		Baltimor	e, MD 2	21201						- 1
	tat	31. Date filed (Month, Day, Ye	7 2007 32.	Fegistrar's Sign	atury A	rede	,									
Regis	stra	NOV 0	1 2001													_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** MONTH NOVEMBER 16, 2007 Tenly William Yonce 8:55AM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 1/2/1933 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 1**⊠** M 2□ F Maryland 213-28-2280 74 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Harford Havre de Grace Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4133 U Way 21078 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 233 amy Injury or other traumatic event, the <u>Medical Examiner must</u> once. Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □**X** es 2 □ No If Yes, Give Year or Dates:1953–55 1 ☐ Yes 2 X No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) 4 Electronic Tech. Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be G. LeRoy Tenly Nana Yonce ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Tenly (Spouse) 4133 U Way Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Erin Cemetery 11/19/07 Havre de Grace, MD 22. Name and Address of Facility
Tarring-Cargo Funeral Home, 21. Signature of Funeral Service UST 21001-3399 Aberdeen, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of): Examiner STAPHYLOCOCCUS COAGULASE NEGATIVE BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed nding physician and use as the burial-trar Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 1 ☐Live birth 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si should t RESPIRATORY FAILURE 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an s certificate has b lirector, page 2 s PLEURAL EFFUSIONS autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Hospital: Other: 217 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this s after deau...al Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

2+1 State

TIMOTHY LOW 31. Date filed (Month, Day, Year) NOV 2 7

29b. Signature and title of contifier

7601 M. D 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

OSLER DRIVE. TOWSON. MARYLAND 21204

Registrar

29c. License number

D24034

29d. Dat

signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) R 16 2007 **Physician** NOVEMBER 11:30AM TIERNEY VIVIAN ANNA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHARLES WALDORF 2239 DELIGHT COURT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JULY 16,1942 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** INDIANA 1 ☐ M 2 ☐ F 65 Director 316-42-5839 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director WALDORF or 28a-f CHARLES MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with U. S. A. 20601 2239 DELIGHT COURT permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23e any injury or other trainment. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Married 2 ➡ Married 1 Yes 2 No If Yes, Give Year or Dates: Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BINDERY COMPANY BINDERY WORK 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DORIS FAGUAR WILLIAM R. KANDETZKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2239 DELIGHT COURT WALDORF, MD 20601 LOUIS E. TIERNEY/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition NOV. 18, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA, VA METROPOLITAN CR 2007 21. Signa we of Funeral Se 22. Name and Address of Facility SERVICE, P.A. RAYMOND FUNL. M00641 5635 WASHINGTON AVE. LA PLATA, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) amin WAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physiclan/Medlcal as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? detached for 5 Other (specify) 1 ☐ Yes 2 ENO 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200 No page 2 s has 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospitel or Attending Physicien: the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide yd ni bellij determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 To the 29c. License number 29d Date signed (Month, Day, Year) 29b. Signarue and title of certifier DORF, Md. 20602 son who completed cause of death (Item 23a) (Type, Print) and address of 32-Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>2007 Month Oct. 30, 14:45 Annie L. Terry 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Takoma Park Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 1 □ M 2 F Days Hours 1924 Alexandria, Va. 224-32-0630 March 8, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 No Maryland | Prince Georges Hyattsville, 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20782 6040 Sargent Road United States 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married **Black** 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None House Wife 12th. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Harris Clarence Newman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1703 Irving Street, N.W. Wash.D.C. 20010 Bertha Harris/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Nov. 8, 2007 Brentwood, Md. 4 Donation 5 DOther (Specify) Ft. Lincoln 3831 Georgia Avenue, N. W. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Washington, D./ C.20011 Latney's Funeral Home MD 278 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): So quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🔀 No 1□ Yes 1 Yes 2⊠ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 K ER/Outpatient 3 DOA 1 Inpatient 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 🛛 Natural

**Physician** /Medical Examiner

the death certificate be executed

The law requires

P.O. Box 68760

Division or Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after death v Hygiene.

permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important; If item 27 Is marked other 1 any Injury or other traumatic event, th

Maryland 21215-0036

Baltimore,

Examiner

Physician/Medical Completed Be ဥ

and physician a as ed by the attending I detached for use as signed by to After this certificate has been si funeral director, page 2 should the ospital or Attending Physician: Thours after death.
uneral Director: After this certificate by filled in by the funeral director, pa

Certification:

Medical

State

Registrar

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 🖾 No

9 Unknown

examiner? 1 ☐ Yes 2 🔀 No

5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and Itle of certifier

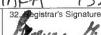
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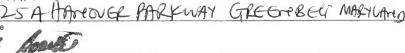
29d. Date signed (Month, Day, Year)

CTOBER 31 2007

31. Date filed (Month, Day, Year) 07 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)





To the Hospital or within 24 hours af To the Funeral D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 7 37820 Certificate of Death 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year 5:02 A 2007 November George White <u>William</u> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Cheverly

If Under 1 Year | If Under 24 Hrs. | Hours | Min. Prince George's Prince George's Hospital Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months 1 M 2 □ F June 19, 1921 Washington, DC 86 220-28-5672 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ty⊟Yes 2 No District of Columbia Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20019 United States 5201 Banks Place, NE 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married African 1 ☐ Yes 2 █XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced American

**Physician** 

/Medical

Examiner

Funeral

Director

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N Was		23a. Pa 1. Firter the disease, or com	plications that caused the	e death. Do n					Approximate Interval Between		
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/Medical		resulting in death)	d								
Examiner		Sequentially list conditions.	b								
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	Attending Physician: The law requires that the death certificate be executed TA SA Cleath.  Total After this certificate has been signed by the attending physician and certor. After this certificate has been signed by the attending physician and certor. After this certificate has been signed by the attending physician and certor. Page 2 should be detached for use as the burial-transit certor.	aw requires that the death certificate be executed as bear signed by the attending physician and 2 should be detached for use as the burial-transit open any injury or other traumatic event, the pleted by Physician/Medical Examiner	The part of the pa	The part of the pa	Deproved on the property of th	To several states and states and states and states are states and states are states and states and states are states and states are states and states and states are states and states and states are states and states and states are states and states are states and states are states and states are states and states are states and states are states and states are states are states and states are	18. Mother's Name (First, Middle, Lasi)   18. Mother's Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Mattie L. 19a. Informant's Name/Relationship (Type. Print)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number or Fural Re Name (First, Middle, Lasi)   19b. Mailling Address (Street and Number o	Description of the paper of the	18. Mother's Name (First, Middle, Maiden Surname)   18. Mother's Name (First, Middle, Maiden Surname)   18. Mother's Name (First, Middle, Maiden Surname)   19. Mattie L. Gough   19. Informant's Name (First, Middle, Maiden Surname)   19. Mattie L. Gough   19. Informant's Name (First, Middle, Maiden Surname)   19. Mattie L. Gough   19. Informant's Name (First, Middle, Maiden Surname)   19. Mattie L. Gough   19. Mattie List only or Town, State 2   12. MacDuff Dr. Ft. Washington, MD 207   12. MacDuff Dr. Ft. Washington,		

State of Maryland / Department of Health and Mental Hygien? 17 37821 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Nov. 6, **Physician** 2007 5:50 P Lillian Ellen Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery National Lutheran Home Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛛 F Yrs 215-52-9898 91 Dec. 18, 1915 Washington, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28e-f show the Medical Examinant transfer coffied at Rockville 1XYes 2 □ No Maryland Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850-3462 USA 9701 Veirs Drive Funeral , or items ; 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othn any injury or other traumatic avent, ODGs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Irene Evans George Edward Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9100 Shad Lane, Potomac, MD Tamara Ann Stern - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 11/10/07 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Punerat Service Lice 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death 234. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Ran /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burlat-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 TYes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9701 Veirs Dr, Rockville, MD Charles Karesh, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State NOV 0 8 2007 Registrar

			For	State	of Mary	yland / I		rtment of H			ental Hy	giene	)		
												Reg. No.	2007	1 37	822
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Virginia Hartman Warrington								Month	Day		3. Time o	t Death
¥	/Medic		4a. Facility Name (If not institution, give			n warr	ingt	On 4b. City, Town, or	Location	of Dogth	Novemb		2, 2007 County of Deal		a ™
)	Examin	er	31 Warrington La		iniber)			Perry				140.		cil	
	Funeral		5. Social Security Number 6. Sec		7. Age (/	In yrs. last bi	irthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt	h	9 Birl	hplace (State	or Foreign
	Director		215-12-2284	]M 2 <b>⊠</b> F	8	36	Yrs.	Months Days	Hours	Min.	(Month, Da March 2			<i>untry)</i> Marylar	nd
	pr ,		Usual Residence of Decedent		144	0c. City, Tow	!	-Min-						404 1	26 - 1 2 26-
	arylai show d at	_	10a. State 10b. County		1	oc. Gity, Tow	VII Of LOC							10d. Inside C 1 ☐Yes	2X No
	the M	Director	Maryland Ceci  10e. Street and Number	1				Perry 10f. Zip Code	ville	e		10a Cit	izen of What Co		
	with la or t be r		31 Warrington Lan	e				,	21903	3		rog. on	U.S.	,	
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral		12. Was Dec		er in U.S.	13. W	/as Decedent of Hi Yes, specify Cuba	ispanic Or	rigin? (Spe	cify Yes or No		14. Race - Ame	rican Indian,	
٥	after or iter		1 Never Married 2 Married	Armed F	2 No			Yes, specify Cuba	in', Mexica Specify:		Rican, etc.)		Black, Whit		
9500-912	ral", c	l by	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or I	Dates:			Lifes ZALINO	Specify.				Specify:	White	
ל	72 h "natu dical	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed;	)	16a	. Deced	ent's Usual Occupa aind of work done of ONOT use retired	ation during mos	st of workir	ng	16b. K	ind of Business	Industry	
121	within	mp	Elementary/Secondary (0-12) Twelve Years	College	(1-4or 5+)		lite. D	Homemake				Б	ersonal	Recide	ance
N	Hygie ther t	ပ္သ	17. Father's Name (First, Middle, Last)					TIOM CINCING		er's Name	(First, Middle,			Reside	SIIC C
yland	ld be ental ked o	To Be	Ernest Edv	vard Ha	artma	n				Ве	ertha B	ierm	ıan		
3	should be filed within 72 hours after death with the Marylan and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	Ĕ	19a. Informant's Name/Relationship (7)	rpe. Print)		198	b. Mailing	Address (Street a	and Numb	er or Rura	I Route Numb	er, City o	or Town, State,	Zip Code)	
, Mar	and 2		Sarah W. Colenda	(Daugh	hter)	3	31 Wá	arrington	ı Lan	e, Pe	erryvil	le,	Marylan	d 2190	03
ore o	of He		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F	Removal from	State	20b. Place o	of Dispos ery, crem	ition (Name of atory or other plac	e)	D	ate	20c. Lo	cation - City or	Town, State	
Ē	Pag tment tant: I		4 □ Donation 5 □ Other (Specify)			Princ	-	Cemeter	-	11/1	5/07	Per	ryville	, Maryl	and
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evonce.	0 0	21. Signature of Funeral Service Linens	THE	MOSA	Sc.	Le	Name and Address e A. Pat rrvville	terso	on &				P.A.	9
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that	caused the	e death. Do							700	Approxima Interval Be	te tween
	Physician	0 1	Immediate Cause (Final disease or condition	_	odon into	Colo	on (	Cancer						Onset and	Death
	/Medical		resulting in death)	Due to	o (or as a c	onsequence		- TCC							
	Examiner	_	Sequentially list conditions, b. — Due to (or as a consequence of):												
-	ted isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Ulsease or injury	onsequence	or):										
	execur and al-trar	xan	that initiated events resulting in death) Last	c Due to	o (or as a c	onsequence	of):								
8/6U	icate be executed physician and s the burial-transit	dical E		d											
Q	tificat g phy as the	Tedi													
X Q Q	leath certific attending p I for use as	an/N	23b. Was decedent pregnant	23c. If yes, οι 1⊡Live		pregnancy □ Fetal deat	h 3□	Ectopic pregnancy	,			1	23d. Date of de	,	Y
	e dea he att	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🖾 No		gnant at tin	ne of death		Other (specify)					Month	Day	Year
J.	hat th d by t let <b>a</b> ch	Phy	9 ☐ Unknown  Part II. Other significant conditions co	entributing to	death but r	not resulting	in the un	derlying cause give	on in Part	1	23e Did t	ohacco i	use contribute to	the cause of	death?
ecords,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	d by	Tax II. Other significant conditions co	minutaning to t	dodin but i	iot rooditing	iii uio uii	acitying sauce give	on mr are						Unknown
Ö	w requ	ete									24a. Was	an	24h Were a	utopsy findings	available
Ď T	The law cate has I page 2 s	Completed									auto perfo	psy prmed?	prior to death?	completion of	cause of
VITal		a)	25. Was case referred to medical						26. Plac	e of Death	1 Yes (Check only o	2k No	1 □Yes	2 □ No	77
	Physician: r this certific ral director,	OB	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 □	] Inpatient	2   ER/O	utpatient	3 DOA Oth	or:				6 ☐Other (Spe	cify)	
n or	iding Phys th. : After this ( funeral dir	n: T	27. Manner of Death  Matural 5 ☐ Pending	28a. Date (Mo	e of Injury onth, Day Y		Time of Injury	28c. Injur Worl	y at k?	2	28d. Describe	how inju	ry occurred		
20	tendil eath. or: A the fu	catic	2 Accident Investigation 3 Suicide 6 Could not be						Yes 2□						
UIVISION	or At after d Direct in by	Certification:	4 Homicide determined	28e. Plac	e of injury ding, etc. (	- At home, fi (Specify)	arm, stre	et, factory, office		1	28f. Location ( City or To	Street ar wn, State	nd Number or R e)	ural Route Nur	nber,
	o the Hospital or Attending P ithin 24 hours after death. o the Funeral Director: After tompletely filled in by the funera	edical C	29a. Certifier 1 Certifying Phy (Check only one)	iner: On the		xamination a									(s)
	To the Hosp within 24 ho To the Func completely f	Mec	29b. Signature and title of certifier	D 11-				29c. License	e number		T		te signed (Mon	th, Day, Year)	
	1.250		+ flasher	tully,	~			0000	t805	0	1	11/	13/07		
•			30. Name and address of person who c						Δi.	0.1.	nMD				
	2		Prashant Shukla,			Parke	Stree	T - TUU	(17)	crete	// / / 0	-16			
I	Sta Regist <i>r</i>		31. Date filed (Month, Pay, Year)	2007 32.	Temotrar s	Signature		barke							

			For State	State	of Mar		ertificate of L			ene g. No 200	7 37823
			Registrar  1. Decedent's Name (First, Middle	a lacti			Timeate of L	Jeani	2. Date of Death	311112 0 0	3. Time of Death
п	Physicia	an	Janet Ouinn	Wickhar	n				Month	Day Ye	
1	/Medic		~							r 7, 200	/ 8:50
j.	Examin	er	4a. Facility Name (If not institution				4b. City, Town, or	Location of Deat	n		
			Hillhaven Nurs	6. Sex			Adelphi	If Under 24 Hrs	2 Date of Birth		George's
п	Funeral		5. Social Security Number	1 M 25 F		'In yrs. last birthday Yrs.	Months Days	Hours Min.	(Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director	}	350-38-8635 Usual Residence of Decedent		89				April 2,	. 1918	Ohio
	and	ł	10a. State 10b. County		1	Oc. City, Town or I	ocation				10d. Inside City Limits
	Many f sho	ō	North								1 ☐ Yes 21€ No
	179 the 28a-	Director	Carolina Mod  10e. Street and Number	ore	;	Southern	Pines 10f. Zip Code		10	Og. Citizen of Wha	t Country?
	with a or		23 Village G	roon			28387			USA	
	hours after death with the Maryland tural; or Items 23s or 28s-f show I Executer invest be rediffed at	Funeral	11. Marital Status	12. Was Dec	edent Ev	erin IIS 13	. Was Decedent of Hi	spanic Origin? (9	Specify Yes or No-		American Indian,
	item item	Ë	1 ☐ Never Married 2 ☐ Marr	Armed F		61 III O.S. 13	If Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		Vhite, etc.
5	rs af	by F	3 ₩ Widowed 4 Divorced	If Yes. G	ive		1 ☐ Yes 2 🕱 No	Specify:		Specify <b>₩</b> }	nite
9500-51212	hou	ed l		t's Education		16a. Dec	edent's Usual Occupa	ation		16b. Kind of Busin	ess/Industry
S	in 72	Completed	(Specify only higher	st grade completed,		(Giv	e kind of work done of DO NOT use retired	luring most of wo	rking		,
7.	with iene. thar	mo	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		Homemaker			Own Home	
	Hyg Hyg other		17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle, N		
a	d be ental	To Be	William Babbit	tt Ouinn			E	lvira Vo	orhees		
Maryland	as 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. I from 27 is marked other than "natural", or froms 23e or 28e-f show to ther traumatic event, it a Medical Examiner must be retified at	F	19a, Informant's Name/Relations	~		19b. Mai	ling Address (Street a			City or Town. Sta	te. Zip Code)
<u>8</u>	d 2 s th an 17 is trau		Sally W. Stem		ghter						MD 20902
ď.	of Health a litem 27 is		20a. Method of Disposition			20b. Place of Disp	position (Name of	T	Date _ 2	20c. Location - Cit	or Town, Stete
Baltimore,	permit. Pages Department of It Important: If Ite any injury or of		1 ☐ Burial 2 ☑ Cremation			cemetery, cr	ematory or other plac		. 8,		
	t. Partitude		`4 □Donation 5 □ Other (S		1		tan Crema	4	007 A1	Lexandria	, Virginia
m m	permit. Departr Importa		21. Signature of Funeral Service	Licensee		F	22. Name and Addres rancis J.	Collins	Funeral	Home Inc	
	40 3 6 G		Horas	Sylven	كمر		00 Univer	sity Blv	d, W, Sil	.ver Spri	ng, MD 20901
	S		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	each line.	e deeth. Do not e	nter the mode of dying	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Alah	o i mo:	r's Disea	~~				
	/Medical		resulting in death)			consequence of):	se				10 years
	Examiner		Conventially list conditions	b							
		ner	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a	consequence of					
	outed nd ransii	Examiner	Cause (Disease or injury that initiated events	c.							
o`	exectan arrial-tr	EX	resulting in death) Last	Due to	(or as a	consequence of):					
8/6U	death certificate be executed e attending physician and nd for use as the burial-transit	dlcal		d							
δ	g ph as th	ed									
X Q Q	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or			Oe			23d. Date o	f delivery
n	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	nant at tir		☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
Ç	the y th	hys	9 Unknown	9□ Unki	nown						
J.	The law requires that the has been signed b bage 2 should be deta	by P	Part II. Other significant condition	ons contributing to	death but	not resulting in the	underlying cause give	en in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
ecords,	uires	β							1 ☐ Ye	s 2 No 3	]Probably 4 ∰Unknown
<u> </u>	w requ	Completed							24a. Was ar	24b. Wer	e autopsy findings available
Ď Y	ne la has ge 2	E I							autops	y prio ned? dea	r to completion of cause of th?
									1 ☐ Yes 2		Yes 2□ No
Vital	Physician: The k r this certificate ha ral director, page 2	Be	25. Was case referred to medica examiner?	Hospital:			Othe		ath (Check only one		
ō	this ald	٠ <u>۲</u>	1 Yes 2 No	1 (_	Inpatient				Home 5 Reside	nce 6 GOther ( w injury occurred	Specify)
	ding P. h. After funer	0	1 Naturel 5 ☐ Pendir		nth, Day	(ear) Injury	Work	(? Yes 2 □ No	250. Describe no	w injury occurred	
S	tend Jeath tor: the	cat	2 Accident investing 3 Suicide 6 Could	not he	m ad Indian			163 2 1140	296 Logation (Ct	and Alumber	or Rural Route Number,
Division	al or Attending F after death. I Director: After d in by the funera	Certification:	4  Homicide determ	nined 286. Place	ding, etc.	(Specify)	treet, factory, office		City or Town		or Aurar Adule Number,
_	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		20a Cartilica XI acris	o Dhucialac: T		mu lean de d		- dat 1 1	a madeful to the		
	Hosi 14 ho Fune Fune tely f	edical	(Check only 2 Medical	Examiner: On the	basis of e	xamination and/or	ath occurred at the timinvestigation, in my op	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	iuse(s) and manno ate and place, and	or as stated. due to the cause(s)
	thin 2 the mple	Med	one) 29b. Signature and the certifie		nner state	u.	29c. License	number	20	9d. Date signed (A	fonth, Dav. Year)
1			SSS. Organization and the continue	10.111	M	4	D31563			vember 8	**
•	20		· LUM	mm	100						
			30. Name and address of person			th (Item 23a) (Type		)	on Contin	. ND 200	01
			Charles Benner		-		Drive, #20	JO, 511V	er spring	, MD 209	.01
	Sta Registr	-05	31. Date filed (Month Pay, Year)	2007 32	ogistrar Malan	s Signature	Coats 1				
X	51311			4	Mar All March and All Street		Shape Billian				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ALLACE AWrenc PHEN VOV 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Drive: Jucen 732 nester Hones If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2□ F Hours Aug 224-74-1539 Director Cooperhill Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 □ No MD Hones Queen Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code death with ec1 21619 rive by Funeral Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or liter uny or other traumatic event, the Medical Examiner uny or other traumatic event, the Medical Examiner. Armed Follows: 1 1 Yes 2 No If Yes, Give Year or Dates: 1968 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🕍 No Baltimore, Maryland 21215-0036 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Men MINISTR lera 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be awrence ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains ec rive hester, Jonnie Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State rematory 11-13-07 Delaware Dover, 4 □ Donation 5 □ Other (Specify) Capitol 21. Signature of Funeral Service Licensee 22. Name and Address of Facility TORBERS FLUERAL CHAPEL, 615. BRADFOLDST. DOVER DE Initucatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** -idneomonth 3 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate clause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Was autopsy performed page 2 s 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home Hospital: 1 Yes 2N No 1 | Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 1 M Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 052830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Local #300 Annepslis, MD 21401 Werner Bestgate 900

DHMH 17 Rev 1/2001

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Marian Louise Wehland 2007 Vovember 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Doctor's Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1 ☐ M 2 💢 F 83 04-07-1924 Maryland 219-12-2615 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Seabrook Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9546 Franklin Avenue 20706 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) banquet food service 11 waitress

18. Mother's Name (First, Middle, Maiden Surname)

Pearl

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Edith

3715 Larkview Ct., Dunkirk, MD

Riddle

11-29-2007 | Arlington, VA

20c. Location - City or Town, State

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

Albert

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Joseph

Jennifer Wildberger, daughter

☑ Burial 2 ☐ Cremation 3 ☑ Removal from State

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

Miller

Funeral

Director

items 23a or 28a-f show ner must be notified at

Director

Funeral

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Be

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death with the Maryland

. Pages 1 and 2 should be filed within 72 hours after iment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

MARHAY

Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burlar-transit

Division or Vital Records, P.O. Box 68760,

Importa any Inj		21. Signature of Funeral Service-Lice	nsee			ddress of Facility R Harmony L		sch Funer		•	Α.	
sician edical miner	lical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical											
rtificate has been sig tor, page 2 should b	e Completed	25. Was case referred to medical				26. Place of De	ath ((	24a. Was an autopsy performed? 1∐ Yes 2.201	24b. Were prior death	to completion	4 Unknown dings available on of cause of	
fter this ce ineral direc	on: To B	examiner? 1 ☐ Yes 2 ☐ No  27. Manner of Death 1. Natural 5 ☐ Pending	Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 I	28c.	Other: 4 Nursing Hinjury at Work?	lome 280	5 ☐ Residence d. Describe how inj	6 □Other (Sury occurred	pecify)		
I Director: A d in by the fu	Certification:	Matural   5   Pending   (Notifier, Day Year)   Highly   Work?									le Number,	
ie Funera detely fille	Medical C		hysician: To the best of my kno miner: On the basis of examina and manner stated.								ause(s)	
To th	Me	29b. Signature and title of ertifier	MD	Š	9c. Li	SH446	9	29d. D	ate signed (M	20	07	
10		30. Name and address of person who	ladehzda.	MD 8118	60	odhuck Rd.	,	hanhan	n, mi	. 20	106	
Sta Regist		31. Date filed (Month, Day, Year)	9 2007 Segistra & Signa	ature St. Ac	est	المريح	,		,			

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National

DHMH 17 Rev 1/2001

dew

			1 - For State Registrar		of Maryland		artment rtificate			and M	lental Hyg	giene Reg. No.	2007	37	826
	Physic /Medi		1. Decedent's Name (First, Middle John P		Whalen						2. Date of Dea Month Novembe	Day	Year 2007		of Death
)	Examir	ner	4a. Facility Name (If not institution 1614 Parham Ro	-	umber)		Sil	ver	Location of Sprin	ng		4c. (	Montg	omery	
į	Funeral Director		5. Social Security Number 094-20-4256 Usual Residence of Decedent	6. Sex 1 M 2 F	7. Age (In yrs. la		If Under Months	Days	If Under : Hours	Min.	8. Date of Birtl (Month, Day Jan • 4,	v. Year)	9. Birth Con N	place (State untry) ew Yor	e or Foreign k
	Maryland a-f show ified at	ctor	10a. State 10b. County Maryland	Montgon		, Town or Lo		er S	pring	J				10d. Inside	City Limits ·
	3a or 28 st be not	al Director	10e. Street and Number  1614 Parham R	oad			10f. Zip	Code 903				10g. Citiz US <i>I</i>	en of What Co	untry?	
320	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ★ Never Married 2 Marr 3 Widowed 4 Divorced	Armed F	2 <b>★</b> No ive		Was Decedor of Yes, spec			gin? (Sp	ecify Yes or No- Rican, etc.)		4. Race - Amer Black, White Speci <b>Whit</b>	, etc.	
9500-6171	vithin 72 hou ene. than "natura ie Medical E	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	st grade completed, College	(1-4or 5+)	(Give life. I	dent's Usual kind of work DO NOT use	k done d retired)	uring mosi		ing	16b. Kin	d of Business/I		
z nue	ld be filed v lental Hygie <b>ked other t</b> ic event, th	To Be Co	17. Father's Name (First, Middle, Phillip J. Wh	Last)	5+	C	athol:		18. Mothe	r's Name	(First, Middle,		Religi	ous	
Mary	nd 2 shou aith and M 27 is mar r traumat		19a. Informant's Name/Relations Joseph P. Wh		./Brothe	(					al Route Numbe			, ,	NY 100
allimore,	Pages 1 and nent of Heamut: If Item		20a. Method of Disposition  ★★Burial 2 □Cremation 4 □Donation 5 □ Other (S		Jale	ace of Dispo emetery, crer Jose					Date 12,		ation - City or		York
ם ם	permit. Departr Imports any inje		21. Sign were if Funeral Service	Col	e	5	00 Un	iver	sity	Blv	Funeral	ilver		MD.	20901
,00700	Physician / Medical Examiner and physician and the purial-transit the purial-transit	dical Examiner	23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respinate to the following	each line.  The ry F (or as a consequence static, F (J) as a consequence (or as a consequence conseque	Arrest ence of): Recurr								Approxim Interval B Onset and	etween d Death
O. DOX	The law requires that the death certificate ate has been signed by the attending physioage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome pf pregnar birth 2 □ Fetal Inant at time of de nown	death 3	]Ectopic pre ] Other <i>(sp</i> e					23	3d. Date of deli Month	very Day	Year
olds, r	quires that the de n signed by the a uid be detached i	by	Part II. Other significant condition	ns contributing to c	death but not resul	ting in the u	nderlying ca	use give	n in Part I.				e contribute to No 3 ☐ Pro		
משבו ומ		Completed									24a. Was a autop perfor 1 Yes	sy	24b. Were aut prior to c death? 1 □ Yes	opsy finding ompletion of 2 \Begin{array}{c}\text{No}	s available cause of
DIVISION OF VIE	ing Phys After this uneral di	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 XNo  27. Manner of Death  1XXNatural 5  Pendin  2  Accident investig  3  Suicide 6  Could referred  4  Homicide	Hospital: 1  28a. Date (Morgation not be 28e. Place	Inpatient 2 E e of Injury oth, Day Year) e of Injury - At hon ling, etc. (Specify)	28b. Time of Injury	M 28	Othe	r: 4□ Nu	rsing Ho	me 5 A Resid 28d. Describe h 28f. Location (S City or Tow	ence 6 ow injury	occurred		ımber,
	To the Hospital or Attend within 24 hours after death.  To the Funeral Director: / completely filled in by the fi	Medical C	29a. Certifier (Check only one)  1   X Certifyin 2   Medical  29b. Signature and title of certifier	A-	e best of my know basis of examinati nner stated.	rledge, death on and/or in	vestigation,	t the tim in my op License	inion, dea	d place, th occur	red at the time,	date and	and manner as place, and due	to the cause	
-	25		30. Name and address of person	F. Se	olon se of death (Itam	1AL 23a) /Tuna	N	ID	030	014	9	ιι	1	007	
,	Sta	ite	John Deekin, MD 31. Date filed (Month, Day, Year)	(Lombar	di Cance	er Cen	ter,	Geor	getow	n Ho	ospital)	) Was	hington	, DC	20007' <sup>N</sup>
	Registr	ar	NOV 0 8	2007	Carren .	K A	ast s								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 November 6, Samuel D'Arcy Williams, Jr. 15:03p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 309 Collins Avenue Hurlock Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Oct. 19, 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**™**M 2□F 83 1924 Maryland Director 218-16-8282 Usual Residence of Decedent 10h County 10c. City. Town or Location 10d. Inside City Limits rai", or iteme 23a or 28a-f shov Examiner must be codified at 1X Yes 2 No Director Maryland | Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 309 Collins Avenue 21643 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1943— 1 ∰Yes. 2 □ No If Yes, Give Year or Dates: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or item eny injury or other traumatic event, the Medical Examinations. Black White etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Be Completed by Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronic Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel D'Arcy Williams, Sr. Mary Ruth Hooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lee Schmitz/Daughter 1601 Pine Avenue, Kirkwood, NJ 08043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory of Delmarva 11/8/2007 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware 21. Si nature of Tuneral Service 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 234. Parf. Enter the disease, or co plications /at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line. Approximate Interval Between Onset and Death **Physician** Myocardia disease or condition resulting in death) MINURS /Medical Due to (or as a conservence of): Examiner Saturating list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the daath certificate be executed for use as the burial-transit Due to (or as a conseque e of): resulting in death) Last Division of Vital Records, P.O. Box 68760, duacco IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Pres 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 No after death.

Director: After this certific
Jin by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home Certification: To 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Iniun 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital within 24 hours a To the Funerei 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) All Medical Examiliner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

11. Date filed (Month, Day, Year) NOV 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

830 Chesapeake

Dr. Cambridge, MS 21613

ician		tate legistrar			Ce	rtificate of L	Death		rgiene Reg. N2	007	37828	_
dical	E	sedent's Name (First, Middle Benny Fr		Villin				2. Date of D Month Noven	ber 4	, 2007	3. Time of Death a 7:10 M	
niner	4a. Fa	cility Name (If not institution 27779 Critter	-			4b. City, Town, or Salish		ealh		ounty of Death		
al or	22	sial Security Number 22–18–9135	6. Sex 1 <b>X</b> M 2 ☐ F	7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	8. Dale of Bi (Month, D 3/10/			place (State or Foreign ntry)   land	
Į.	10a. S		omico		y, Town or Lo						10d. Inside City Limils 1 ▼Yes 2 □ No	_
Director	10e. S	Street and Number 7779 Crittend				10f. Zip Code 21801			10g. Cîtîze US	en of What Cour	ntry?	_
by Funeral	11. Ma	arital Status  ☐ Never Married 2 ☐ Marri	ned 1 1 Yes	cedent Ever in U forces? 2 No live Dates: Nav		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 1/21 No	ispanic Origin? in, Mexican, Po	? (Specify Yes or Nuerto Rican, etc.)		4. Race - Americ Black, White, Specify: Wh		-
Completed		15. Deceden	nt's Education st grade completed		16a, Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of )	working	16b. Kind	d of Business/In	dustry	
е Сод		12 ather's Name (First, Middle,			mac	hinist	18. Mother's	Name (First, Middle	1	DuPont		-
To Be		Everett Willi						e Graveno				
	19a. I	Informant's Name/Relations usan Flanagar		c		ng Address <i>(Street a</i> '79 <b>Critt</b> e						
once.		Method of Disposition  Surial 2 Cremation	3 □Removal from		cemetery, crei	osition (Name of matory or other plac		Date		ation - City or To		
ن د	` 4	□Donation 5 □Other (Signature of Funeral Service	Specify)	Ma	Ceme	Memorial tery		/9/07			ings, MD	
SUC B		Yall RX	Jeener	CESTO		Holloway 501 Snow	Funer Hill	al Home F kd., Sali	rofes soury	sional , MD 21	Associatio	٢
Examiner	cause Cause that in result	entially list conditions, list of introductions list of introductions list of introductions list of introductions list of introductions list of introductions list of introductions list of introductions list of introductions list of introductions list of introductions list of introductions list of introductions list of introductions list conditions list of introductions list o	c	o (or as a conseq	uence of/	vessel d						_
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Lest) Nov 15, 2007 Whittington 12:55am Virginia 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Allegany Cumberland Devlin Manor Nursing Home | Fit Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | OCT 15, 1930 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2√□F 217-28-0730 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√1 Yes 2 □ No Allegany Cumberland 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number 1500 Oldtown Manor Apt. F 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Stetus 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1□ Yes Z No Specify: Specify: white 3 ☐ Widowed ¥ ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gladys Blackburn Weber Virgil Weber 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1500 Oldtown Manor Apt. F Cumberland MD 21 19a. Informant's Name/Relationship (Type, Print) MD 21502 Fred Winterly friend 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Scarpelli Funeral Home, P.A. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 11/16/2007 Cresaptown MD 4 ☐ Donation \_5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22. Nar</sup>Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☑ Ño 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 468 2 110

Physician /Medical Examiner

signed by the a

After this certificate har funerel director, page

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

þ

Completed

Be

Medical Certification: To

**Physician** 

/Medical

Examiner

MD

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumetic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

Examiner attending physician end for use as the buriel-trensit The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medicai

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 ☐ Yes 2 ☐ No

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h	(Check	only	one)	

25.	examiner?		o medica
	1 ☐ Yes	5 <u>H</u> 40	
07	Manageral	Danth	

1. Natural

2 Accident

4 \( \text{Homicide} \)

3 Suicide

5 Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

t☐ CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D0017565

MD

26. Place of Deat

15, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Bollino

Registrer's Signature

L20212

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item# 23a.PartII,QACHD,FH Reg. No. Certificate of Death 11/06/07,LP 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician ELIZABETH GANNON WOODFORD DEN oven /Medical 200 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City\_Town, or Location of Death Examiner Vimor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Days Hours 1 □ M 2 🔀 F 213-22-7835 JULY 3, Director 1929 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes X No Director QUEEN ANNE'S MD CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 OVERLOOK LANE 21617 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 REAL ESTATE BROKER REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be THOMAS C. GANNON NELLIE CONNOLLY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WALTER E. WOODFORD, JR./HUSBAND 212 OVERLOOK LANE, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTRE, LLC 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 11-6-2007 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signal re u F FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-trai P.O. Box 68760 attending physician certificate be Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 3 Ectopic pregnancy jo Day 4☐Pregnant at time of death 5 Other (specify) be detached the 9□Unknown ģ 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After it Certification: (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title KES CCC ovember 5,2007 S son who completed cause of death (Item 23a) (Type, Print) of Raltimore e Evens 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2007

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rame, Zamara		1-For State Control of Certificate of Registrar			. No. 2007	3783
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Stanley Edward Wharton		2. Date of Death Month November	Day Year	Time of Death 1626 hrs
			b. City, Town, or Location of Death		4c. County of Death	
		6 South Bentz Street	Frederick		Frederick	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 217-70-8161 2M 2 F 49 Yrs.	Months Days Hours Min	_	(MM/DD/YYYY) 9. Birthp Foreign Coun	
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati			1	0d. Inside City Limits
<b>*</b> •	5	MD Baltimore Gwynn Oa	ak			Yes 2 No
in the Maryland 23a or 28a-f show notified at once,	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Countr	y?
Vith the Maryle s 23a or 28a-f	a		21207 s Decedent of Hispanic Origin? ( Sp	pecify Ves or No-	USA 14. Race - America	n Indian Black
death v r item	Funeral		es, specify Cuban, Mexican, Puerto		White, etc.	Transfer, District
s after rai", o	by F	3 Widowed 4 ADivorced of Yes, Give Yea 1977—1980 1	Yes 2 No specify:		Specify: Whit	
2 hour "natu			t's Usual Occupation (Give kind of vost of working life. DO NOT use reti		16b. Kind of Business/Ind	ustry
21215-0036 Juld be filed within 72 hours at Mental Hygiene. marked other than "matural ic event, the Medical Examin	Completed	12 C	arpenter		Constru	ction
15-00 filed withi I Hygiene, ed other ti	Be Co	17. Father's Name (First, Middle, Last) Edward Samuel Wharton	18.Mother's Name	(First, Middle		
212 ould be d Ment s mark	To B		Address (Street and Number or I			(ip Code)
MD nd 2 sho alith and em 27 is		Shirley Ann Wharton/Mother 1667	Exeter Road Wes		r, MD 2115	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural?, or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation 3 Removal from State crematory or oth	ition (Name of cemetery, her place) 11/2 remation, Inc	1872007		
ultim nit. Pa artmen portant		4 Donation 5 Other Specify.	ineas Advess of Facility Hom	o and Ch	Hampstead,	
Ba perr Dep Imp		Gallet 100	2 Washington Roa	d Westm	inster, MD	21157
Physician /Medical		23a Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.		or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
taminer		Immediate Cause (Final disease or condition resulting in death)  a. Hyl thermia complicating Due to (or as a consequence of):	alcohol use			Deaul
	۰	Sequentially list conditions, b.				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ecuted and - transit						
re exection exection executed and an executed an executed and an executed an executed and an executed an executed an executed and an executed an executed an executed and an executed an executed an executed an executed and an executed an execu	Medical	X UNPENDED AMENDED #23a,PII.27.28a-f.perME.9	9873 11/29/07 TT			
760, ficate be exe g physician a sthe burial -					23d. Date of delivery	V Voor
Box 687 E death certific the attending 1 ed for use as the	iciar	past 12 months?  1 Live birth 2 Fe 4 Pregnant at time of death 5 Ot	tal death 3 Ectopic pregnature (Specify)	aricy	Month Da	y Year
	Physician	Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I	23e. Did tob	pacco use contribute to the	e cause of death?
Division of Vital Records, P.O. rat or Attending Physician: The law requires that it all birectors. After this certificate has been signed by led in by the funeral director, page 2 should be detact.	<u>م</u>	Cirrhogia of liver			2 No 3 Proba	_
ords w requires been as been should	Completed			24a. Was a		psy findings available mpletion of cause of
tal Reco cian: The law certificate has	ome			perform 1 <b>V</b> Yes 2		2 No
ital Recision: The scertificate rector, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check		2id C - d Oth	
1 of Vi ling Physi After this funeral dir	<u>ا:</u>	27. Manner of Death 28a. Date of Injury 28b. Time of I			Residence 6 Other:	scene
ision Attendin r death. ector: A	Certification:	1 Natural 5 Pending (Month, Day, Yeár) 2 X Accident Investigation Fnd 11/14/2007 Fnd 4:2	21 pm 1 Yes 2 X No	Exposure t	to low environm	mental
Divis tal or At al Direc al Direc	rific	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	et, factory, office building, etc.	28f. Location (S	treet and Number or Rura ate) Z St. Frederick	
Hospita 24 hours Funeral		29a. Certifier	rred at the time, date and place, and			
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.				
	Š	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	
		30. Name and address of person who completed game of death (from 322)	O.C.M.E.		November 15, 200	
		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn S	Street, Baltimore, MD 2120	)1		
S Regis	tate trar		es o			
DHMH 17 Rev 1/2		ORIGINA	L			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Christine R. Wir		in State o	f Maryland /		ertment of			Mental		Ü	200	7 0	702
Physici		Registrar  1. Decedent's Name (First, Middle,Last)		001	imodio oi	Dodin			2. Date of De			3. Time of E	283 Death
Medical Exami		Christine Ro.  4a. Facility Name (if not institution, give s		dste		b. City, To	wn orlo	cation of D	Month Novemb		Year 007 c. County of Deatl	2010 h	rs
1		1 East Mayer Drive	dect and number)			Finksb		cation or b	,cau		Carroll		
Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. la	ast birthday)	If Under		If Under 2		Birth(MM/	/DD/YYYY) 9. Bir		e or
Director		214-54-9777 1_N	2 <b>X</b> F	57	Yrs.	Months	Days	Hours	Min. Aug	2, 19	950 G	ountry) rvlanc	.
ıy		Usual Residence of Decedent  10a. State 10b. County	1	Inc City	Town or Locati	on						10d. Inside	
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arylanı 8a-f sl	Director	10e. Street and Number		-	-	10f. Zip C			)	10g. Citi	izen of What Cou	intry?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menal Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show injury or other trannatic event, the Medical Examiner must be notified at once.		1 East Mayer Drive	<u> </u>					2104	8		USA	Δ	
th with terms 2 st be n	Funeral	11. Marital Status  1 Never Married 2 Married	2. Was Decedent B Armed Forces?	ver in U.					? ( Specify Yes or I uerto Rican, etc.)	No-	14. Race - Amer White, etc.	rican Indian, E	Black,
ter des			1 Yes 2	No	1	Yes 2	No s	specify:			<sub>Specify:</sub> white		
ours af atural	d by	15. Decedent's Education (Specify only	r Dates:	oleted)	16a. Deceden	t's Usual O	coupation	(Give kind	d of work done	16b. I	Kind of Business	/Industry	
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-003 I withi giene. iher th	Сотр	12 17. Father's Name (First, Middle, Last)						Mother's N	Name (First, Middle	Maiden			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	BeC	Woodrow Robbi	ns				10.		lia Patr		(Surrame)		ŀ
21 thould in Mer is man	٩	19a. Informant's Name/Relationship (Typ							r or Rural Route N			e, Zip Code)	
, MD and 2 sho ealth and em 27 is	- }	Tawnya L. Yates, o	laugnter	20h I	J SE				erstown,		Location - City of	r Town State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 3	Removal from Sta	e (	crematory or oth adow Br	er place)		· ·	1/08/200		Westmir	•	
nit. Pa artmen ortant		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	e	Me				Facility	Myers-Du	rbor	aw Funar	ral Hom	ne l
Dep Depriy		Justi R. I	Surboun		) 9	1 Wil	lis :	Stree	et, Westm	inst	er, MD 2	21157	
Physician /Medical	1	23a. Part I. Enter the disease, or complic failure. List only one cause on each		he death	. Do not enter th	ne mode of	dying, su	ch as card	liac or respiratory a	arrest, she	ock, or heart	Between	ate Interval Onset and
caminer		and the second second	narp Force Inju		4).							D	eath
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of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phy lumeral director, page 2 should be detached for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom  1 Live birth		<sub>2</sub> Fe	tal death	3	Ectopic pr	regnancy	23	3d. Date of deliver Month	Day	Year
eath ce attence for use	/sici	1 Yes 2 No 9 V Unknown	9 Unknown	ime of de	eath 5 Otl	ner (Specif	(y)						1
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FVi Physi er this eral dir	ဦ	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injur	v	ER/Outpatient 28b. Time of I		ic. Injury a		lursing Home 5		ence 6 Othe	er: Scene	
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ivision or Attend after death. Director:	fical	2 Accident Investigation 3 Suicide 6 Could not be	Nov 2, 2007 28e. Place of Inju	ıry - At h	1957 hrs ome, farm, stree	et, factory, c	office buil	ding, etc.			and Number or R	ural Route N	umber, City
Divis Hospital or A 24 hours after Funeral Dire	Certification:	4 V Homicide determined	(Specify) Mot	ile Hor	me				or Town 1 East May	i, State) er Drive,	, Finksburg, Ml	)	
Division of Vital Records, P.O. Box 6876 with 24 hours after death certificate within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: 0											
To the within To the comple	Medical	29b. Signature and title of certifier	nd manner stated.				License n				Date signed (Me		ar)
MIL		CANADUL	200a	in			O.C.M.				vember 3, 20	_	,
3		30. Name and address of person who con	npleted cause of de	eath (Item	23a)								
		Carol Allan, MD Assistant	Medical Exam	,	111 Penn S	Street, Ba	altimore	e, MD 2	1201				
St Regis		31. Date filed (Month, Day, Year)  NOV 0 7 20	32. Redistrar		ire do	24 1 2							
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#### State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1449 Rose Marie Amoriello 2007 November 21, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Upper Chesapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 219-26-2783 94 01-05-1913 Director Pennsylvania Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show пs 23a or 28a-f shov must be notified at 1 ☐ Yes 2X No Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2920 Suffolk Lane U.S.A. 21047 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Department of Health and Mental Hygiene. Inatural, or iter important: if item 27 is marked other than "natural," or item any Injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Schoo1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pasquale Stabile Elizabeth Gianelli Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace A. Ash (Daughter) 2920 Suffolk Lane Fallston, MD 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Holy Redeemer Cem. 11-24-2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Fungral Sepice Licenses Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 months -grad disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mont Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner Peath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural 1 Yes 2 No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check o one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lovember 22nd, 207 D45390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myo Min (MD.) GOZ South Atword Road #200, Bel Air, MD 21014 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State amend #5Per FH G877 3/21/08 JH Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year NOVencore 27 2007 **Physician** Anderson Kerry /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALLIMORE WAShington Medical Center BURNIE ANNE ARUNDEL 5. Social Security Number 8. Date of Birth (Month, Day, Y Sept. 11 If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 940 1□**y**1 2□ F 67 ATTENTOWN PA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 329 B Margate 21060 USA Drive Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐Never Married 2 ☐ Married "natural", or white 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced HOCIEPSON K or than "natura", the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 I nent of Health and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7<sup>College (1-4or 5+)</sup> State of Maryland District Court Commission 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard G Anderson Beatrice Quinn ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) in portant: If item 27 in a y injury or other tra Robert Mauger 307 Willowbrook Lane Royersford PA 19468 Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department 4 Donation 5 Dother (Specify Metro Crematory Inc. 11/28/07 Baltimore MD 22. Name and Address of Facility 21. Signatur of Funeral Service Lice Stallings Funeral Home P.A. 3111 Mountain Road Pasadena.MD 21122 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the dis se, or complications the Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) eumons /Medical Due to (or as a consequence of): Examiner ung Concer tatio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ρ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s certificate 1∐ Yes or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA s after death.

I Director: After this of in by the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennington 4710 amacher IVa

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Ö

Records,

Division or Vital

PNYLL

31. Date filed (Month, Day, Year)

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900

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SING



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:15 P M November 23, 2007 Duane Edward Allen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**∕** M 2□ F Hours Director 12, 1969 216-08-8287 37 Maryland Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits or 28a-f ehow a notified at 1 ☐ Yes 2X No Directo Maryland Harford Aberdeen the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or other traumatic event, the Macical Examinar must be. 21001 USA 6 Holly Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify: Specify: 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) Emergency Medical Technician Public Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should by Department of Health and Menta Importent: if Item 27 is marked any injury or other traumatic events. ၉ Raymond Eugene Allen Doreen Lynn Dorn 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Holly Avenue, Aberdeen, Maryland 21001 Doreen Allen / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 11-28-07 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 21. Signature of Funeral Service Licensee Kurrell ly 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition MYOCARDIAL **Physician** KUTE 6 hours resulting in death) /Medical Due to (or as a consequence of): Examiner SEPTIC Shock 24 hours equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the ettending physicien and hed for use as the burial-tran Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIADETES 1 🗌 Yes 2**/27**00 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Anpatient 1 Yes 2 7No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Watural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No n 24 hours after death ne Funerel Director: A bletely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge ideath occurred at the time, date and plane, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Cari 11-23-2007 D0056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jason Birnbaum M.D. 500 Upper Chesapeake Dr., Bel Air, MD 21014 31. Date filed (Month, Day, Year) 32. Aggistrar's Signature State Registrar

O. Box 68760.

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marytand Department of Hearth and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Brown /Medical 4b. City, Town, or Location of Death Randall Stown Eacility Name (If not institution, give 4c. County of Death Examiner Baltimore 5. Social Security Number Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 1 □ M 2 🔀 F 111.30. 769 74 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits \*how 27 is marked other than "natural", or itema 23a or 28a-f shot treumatic event, the Madical Examinar must be nutitive at Baltimore 1 Yes 2 No Windsor Mil Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Dauber 18 Completed by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 200 No Specify: Black Specify 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Church Musician Zyears 12th grade 17. Father's Name (Birst, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be 1)rango Pauline 19a. Inform s Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Brown Windsor Mill 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Depertment of I Important: If its eny injury or o once. 1 XBurial 2 ☐ Cremation 3 □Removal from State 11/28/07 King Memorial 4 ☐ Donation 5 ☐ Other (Specify) Windson Mill, MP 21. Signature of Funeral Service Licensee 22. Name and Address of Facility aughen C. Greene Funeral Services -Road Randallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician -cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Medical Certification: To Be Completed by Physician/Medical Examiner physicien and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death signed by the aid be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes 1 Yes 2 2 N within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 2 (UNO Other: 1 🗆 Yes 1 Inpatient 4 ☐ Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how insury occurred 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death becured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. 2 ignature and title of certific 29d. Date signed (Month, Day, Year) death (Item 23a) (Type Print) 31. Date filed (Month, Da Aegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kenneth C. Brown State of Maryland / Department of Health and Mental Hygiene 2007 37838 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day November 2, 2007 Medical Examiner 1041 hrs Kenneth Charles Brown 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Petro Truck Stop Elkton Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Min. Director 1X M 2 F CountryCanada UNK 11/30/1953 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No or 28a-f shov 23a or 28a-f shov notified at once, Ontario Woodstock Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 98 Camrobert Street N4S8X4 Canada 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 3 Widowed 4 Divorced If Yes, Give Year Yes 2X No specify: SpecifWhite ρ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than Baltimore, MD 21215-0036 Truck Driver Trucking 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Owen H. Brown Gloria M. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Doucett (wife) 98 Camrobert Street Woodstock, Canada N4S8X4 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Burial 2 Cremation 3 X Removal from State Canada Canada 1115107 Donation 5 Other Specify 22. Name and Address of Facility Schimunek Funeral Homes, 21. Signature of Funeral Sprvige Licensee 9705 Belair Rd. Nottingham, MD 21236 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Cardianevaly Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED by the attending physician ached for use as the burial To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. perME.g873. 11/29/07 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? this certificate ✔ Yes 2 1 🗸 Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural 5 Pending Yes 2 Director: d in by the f Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 3, 2007 Morrie 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Day)

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

Yea 2

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William N. Bailey 2007 November 2:45p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1714 Gemini Drive Svkesville Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Hours 1√2 M 2 □ F 161-22-1480 March 29 1931 PA Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD Carroll Sykesville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1714 Gemini Drive 21784 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Tyyes 2 □ No Korea If Wes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No white þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) health care Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) registered nurse permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygier Important: If item 27 is marked other tt any Injury or other traumatic event, the once. 1 and 2 should be filed wi Health and Mental Hygier em 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Bailev Dora Shaffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Bailey (spouse) 1714 Gemini Dr., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beth Shalom Cemetery 11-30-07 Taylorsville, MD 22. Name and Address of FacilitHaight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, iscoung to immediate cause. Enter Underlying Cause (Disease or injury that initiated events reculting to death), Last Due to (or as a consequence of) Examiner certificate be executed for use as the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68766 nding physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. I signed by the side be detached to 1 ☐ Yes 2 ☐ No detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed this certificate 1 ☐ Yes 2 ☐ No us after death.
urs after death.
veral Director: After this cen...
... by the funeral director, pr 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by the 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year)

10

30. Name and address of person who

State Registrar Street 1

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

The Word

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 25,2007 **Physician** 6:209 M <u>Joan M. Barkalow</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Home Roland Park Place Nursing Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 01.24.1917 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 📑 F 238.32.1861 Yrs. 90 Director IN Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. Count 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? · 23a 830 W. 40th. Street 1016 Funeral 21211 Pages 1 and 2 should be tiled within 72 hours after death A . 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ot Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Robert Metzger Leslie Shaw 19a. Informant's Name/Relationship (Type. Print) Department of Health and Important: If Item 27 is m any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Woodlawn Rd. Baltimore, MD 21210

Date | 20c. Location - City or Town, State <u>Joanna B. Kann/daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11.27.07 | Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee M01443 Alternatives <u>8717 Green Pasture</u>s Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular disease and strokes **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, than, leading to himodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Director (of selfaconsequence of) Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 1 M 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Vatural Injury n 24 hours after death.

le Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 📉 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 26, 2007 D13657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TO ISABELLE TACGREGOR, 830 W. 40 Th. STREET, BALTIMORE, TO 21211 31. Date filed (Month, Day, Year) 32, Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Hearth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BACER. Day **Physician** HAROID 2007 2:20P Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8322 Barkwood Court Howard If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, Year) Months Hours 1 → M 2 □ F 301.26.8988 Usual Residence of Decedent MD KY 79 01.10.1928 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No MD Howard Director Jessup 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U . S . A .

14. Race - American Indian,
Black, White, etc. 8322 Barkwood Court 20794 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 AYes 2 No. If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Koyea Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Armond Baker Grace Miller 19a. Informant's Name/Relationship (Type. Print)

Ethel Louise Baker/Wife

Louise Baker/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8322 Barkwood Court, Jessup, MD 20794
ace of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2° ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 11.26.07 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityCremation And Funeral Balto M01443 Alternatives 8717 Green Pastures Dr. MD 9 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DIAbetes Mellitus Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner HYPERTENSION Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician for use as the hurial þ page 2 should certificate or Attending Physician: After this filled in by

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other than Injury or other traumatic event, this once.

**Physician** /Medical

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

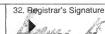
within 24 hours after death To the Funeral Director: 511

State

5450 Knoll worth DV. Sulte 260. 31. Date filed (Month, Day, Year)

29b. Signature and title of Certifie

(Check only one)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29d. Date signed (Month, Day, Year)
Nov 26, 2007

Colombia MD 21045

Registrar

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	

ion	1. D	State Registrar ecedent's Name (First, Middle, L	ast)				2. Date of D	eath		3. Time of	Death
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ical ner		acility Name (If not institution, g			4b. City, Town,	or Location of De			County of Death		
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	$\vdash$	4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	anana —	Green	Mount Cremat	ory Nov	17,2007	L Ba.	ltimore,		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27, 2007 Month **Physician** November Hazel Mae Brow 6:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Hospice House Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Aug. 26,1922 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days 85 135-16-1778 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 🔀 No Director Maryland Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 370 Fleagle Rd. 21061 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 9 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked oth Be John Jacob Petreson Hazel Williamson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: if item 27 any injury or other to Beverly L. Brow / Sister 370 Fleagle Rd., Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov. 1 ☐ Burial 2 ☑ Cremation 3 Removal from State Metro Crematory, Inc. 2007 Catonsville, Maryland 4 ☐ Conation 5 ☐ Qther (Specify) 21. Sign ture of Foreral Service Licenses 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Box 687607 Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate | the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 26. Place of Death (Check only one)

Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{XOther} \) (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural
2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide No Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

Registrar

State

Sw blen Burne MO

of person who completed cause of death (Item 23a) (Type, Print)

2007

Hegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 00 OV 2007 10:03 /Medical 4a. Facility Name (If not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Colombia Howar If Under 1 Year | If Under 24 Hrs. ial Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 💢 F Hours Min. 70 217-34-3024 Director October 12, 1937 Marvland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or item s 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 □ Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 8610 Snowden River Parkway U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Parks** Mary Alberta Stewart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8000 Keeton Rd. Elkridge, Maryland 21075 Mr. Roland T. Brooks Son Department of Health Important: If Item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 4 ☐ Denation 5 ☐ Other (5 3 Removal from State 11/24/07 Baltimore, Maryland Lorraine Park Cemetery nation 5 Other (Specify) 21. Sanatyle of Fundral Service Licen 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebro vasularace. cute /Medical Due to (or as a consequence of): Examiner terioscleros, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed labet burial-trar and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: f yes, outcome pf pregnancy □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by been signal 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy perform 9/0 Division or Vital 1☐ Yes 2[ 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 R/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Hospital or Attending 1 Natural 5 Pending investigation Iniurv ithin 24 hours after death.

the Funeral Director: Afformpletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated. To the within 29b. Signatu 29c. License numbe 29d. Date signed (Month, Day, Year) 2 JACKSON, who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 1105 31. Date filed (Month, Day, Year 32. Registrar's Signature State NOV 2 Registrar 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 7

			For State Registrar		State of Ma	ryland /	Cei	artment of H rtificate of I	lealth D <i>eath</i>	and N		giene Reg. No.	200	7	3784	6
f	Physicia	an	1. Decedent's Name	(First, Middle, Las	st)						Date of De     Month	ath Day	Ye	ar	3. Time of Death	
	/Medic Examin	al	Brigida 4a. Facility Name (If		e jar e street and number)			4b. City, Town, or	Location		November		2007 County of D	eath	7:00 P	M
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	and w t		Usual Residence of I 10a. State	Decedent 10b. County		10c. City, To	wn or Lo	cation						10	d. Inside City Lim	nits
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land	be filed within 72 hours after death with the Marylar at all Yigiene. And Hygiene. Active than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (/	First, Middle, Last)	)				18. Moth	ner's Name	(First, Middle	Maiden	Surname)			
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Mar	d2sh thand 7ism traum		19a. Informant's Na		Type. Print)	- 1		ng Address (Street					Town, Stat	e, Zip (	Code)	
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within Ext brouss after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one)	Certifying Ph	ysician: To the best of niner: On the basis of and manner state	examination a	ge, deatl and/or in	n occurred at the tin vestigation, in my o	ne, date a pinion, de	and place, eath occurr	and due to the red at the time,	cause(s) date and	and manne place, and	r as sta	ited. the cause(s)	
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and		Usual Residence of Decedent  10a. State 10b. County	10c, City.	Town or Lo	ocation					10d. Inside City Limit	te
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		Claudia B. Blosser			F Canter						
S 7 1 1		20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ F	20b. Pta	ace of Dispo	osition (Name of matory or other pla	- 1	Date			City or Town, State	
altimore, mit. Pages 1 ar partment of Hea portant: if item. y injury or othe		4 ☐ Donation 5 ☐ Other (Specify)	Unic	on Cha	pel UMC	Cem.	11-19-0	7	Joppa.	Maryland	
Baltimo permit. Page Department of important: if any injury or		21. Signarute of Funeral Service Licens	ee	2	Name and Addre	ess of Facili	itv				
	1	23a Part1 Enter the disease or compa	ation that caused the death	1	317 Coke	shurv	Rd A	hinada	n, MD	21009 Approximate	
Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final				rig, sucri as	s cardiac or resp	matory arres	ι,	Interval Between Onset and Death	
/Medical		disease or condition resulting in death)	Due to (or as a conseque		AILURE						
Examiner		Sequentially list conditions	)	,							
1 /B ==	iner	Sequentially list conditions, if any, leading to immediate sause. Enter or or or or or or or or or or or or or	Due to (or as a conseque	ence of):							
executed in and lal-transit	Examiner		Due to (or as a conseque	ence of):							
be be				01,00 01,1							
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medica		d								
<b>BOX</b> sath cer	an/N	230. Was decedent pregnant	23c. If yes, outcome pf pregnan 1 □Live birth 2 □ Fetal		]Ectopic pregnanc	v				of delivery	
at the dea by the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown		Other (specify)				Mont	th Day Year	
Hat the ed by the detache		Part II. Other significant conditions co	ntributing to death but not result	ting in the u	nderlying cause giv	en in Part l	. 2	3e Did toha	cco use contrib	bute to the cause of death?	
COTGS, Parents that the second of the second	d by				ndonying oddoo gri	ren in ranci				3 Probably 4 XUnknow	vn
w req	Completed							4a. Was an		ere autopsy findings availab	_
The la	omp							autopsy performe	ed? pr	ior to completion of cause of ath?	
	Be C	25. Was case referred to medical examiner?				26. Place	e of Death (Che	☐ Yes 2 <b>]</b> ck only one)		□Yes 2□No	_
Or VITA Physician: r this certific ral director,	ToE	1 ☐ Yes 2 <b>X</b> No	lospital: 1 Inpatient 2 E	· · · · · · · · · · · · · · · · · · ·		4 🗆 Ni	ursing Home	Residen	ce 6 <b>X</b> IOther	r (Specify) HOSPICE	
E E	ion:	27. Manner of Death  1   Natural 5   Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo			escribe how	injury occurre	d	
VISION Attending or death. rector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Hamicide determined	28e. Place of injury - At hon	ne, farm, st		Yes 2		cation (Stre	et and Number	r or Rural Route Number,	
Saffer saffer in Direction in D	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	)	, , ,		256	ity or Town,	State)	or rioral rioute maniber,	
DIVISIO DIVISION Hospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fi		29a. Certifier (Check only 2   Medical Exam)	sician: To the best of my know ner: On the basis of examination	rledge, deat	h occurred at the ti	ime, date a	nd place, and di	ue to the cau	ise(s) and man	nner as stated.	
To the Hosi within 24 ho To the Func completely f	Medical	Ollej	and manner stated.		-		aur occurred at				
or with	<	29b. Signature and title of certifier			29c. Licens			290	,	(Month, Day, Year)	
. Lf		20 Name and address of person who a	produced course of death (them)	02a) (Tun-		37	25		// //	4/07	
10+1		30. Name and address of person who co  DR. TARIO MAHMOOI			· ·	ттмо	NIUM, M	D 2100	13		
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu			* TI-10	TIOITS I	J_2103	, ,		
Registr		NOV 2 8 2	007	E 1	SEARI						
DHMH 17 Rev 1/20	001			8.	ICINIAL						
				OF	IIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Year Wanda Darlene Caspar 07 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore

If Under 1 Year | If Under 24 Hrs. Med Chr Maryland University 5 8. Date of Birth (Month, Day, Year) Dec 27, 1963 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1 □ M 2√X 578 96 2339 43 Director Washington DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits · 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland | Calvert Lusby 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or 1522 Cove Pt Road 20657 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or items 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ð Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 is marked other tha any Injury or other traumatic event, the Self Employed Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joel Lee Soots, Sr. ပ Rosa Lee Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James P. Caspar (Husband) 1522 Cove Pt Road, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory Nov 16, 2007 Clinton, MD 21. Signatu Fun Service Lice 22. Name and Address of Facility Lee FuneralHome, Inc 6633 01d 120015 Alexandria Ferry Road, Clinton MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rade /Medical (or as a consequence of): 6 lns Examiner Sequentially list conditions, if any, leading to indirectate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DERTIFICATION APPROVED Due to (or as a consequence of) 6 lus attending physician and for use as the burial-transit Exami radure belvic Due to (or as a consequence of): 6 line Box 68760 The law requires that the death certificate be Physician/Medical velride IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9 Unknown been signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has to page 2 s autopsy perform this certificate 2 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1XYes 2 No Hospital: 1 ☐ Inpatient 2 【 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 28a. Date of Injury funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending After 1 Natural 5 Pending 1 ☐ Yes 2 🕱 No motor vehicle collinon investigation neral Director: A filled in by the fu 11/09/07 2046 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after Street Perusylvanie Aue/Brooks 1. 20743 To the Hospital of within 24 hours aff Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tot AU4176435M16773 NOV 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Kashu Malle Greene

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

8

Registrar's Signature

Baltimore

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Item 25 per me, g873,1	Depa 1 <b>/20</b>	rtment of H <b>07dbb</b> incate of 2	ealth and <b>S</b> ath	d Mental Hy	giene Reg. No. 2 N	07 2701.0		
	Physici		1. Decedent's Name (First, Middle, Last)  THERESA CLARIC				Month	2. Date of Death 3. Time of D			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  HARBOR HOSPITAL		4b. City, Town, or BALTIMO			4c. County	4c. County of Death		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 1 M 2 1 Age (In yrs. last bit 7 Age (In yrs. last bit 1 Age (In yrs.	irthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	din. 8. Date of Birt (Month, Da	h v. Year)	Birthplace (State or Foreign Country)     Maryland		
Maryland 21215-0036	D		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	vn or Loc	ation				10d. Inside City Limits		
	h the Ma r 28a-f s notified	Director	Maryland Baltimore Baltimore   10f. Zip Code   10g. Citizen of What Country?								
	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "netural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		3715 Annapolis Road		21227			USA			
		by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Jt.	as Decedent of Hi Yes, specify Cuba ☐ Yes 2 ☑ No	spanic Origin? n, Mexican, Pi Specify:	(Specify Yes or No- uerto Rican, etc.)		e - American Indian, k, White, etc. : White		
		Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)		work done during most of working Tuse retired)			16b. Kind of Business/Industry			
	filed within Hygiene. Ither than "	Ö	12 17. Father's Name (First, Middle, Last)	domei	maker	18 Mother's I	Name (First, Middle,	Own I			
	should be ind Mental marked o	To Be	Maurice Mulcare			Flore		walden daman	Cook		
Man	12 sho h and 7 is ma trauma						Rural Route Numbe				
	s 1 and 2 f Health tem 27 i		20a. Method of Disposition 20b. Place of	of Dispos	ition (Name of	- 1	Baltimor Date		land 21227 City or Town, State		
E C	Pages ment of I ant: If Ite ury or o		IX Burial 2 Ucremation 3 Unemoval from State		atory or other place rk Cemete	,	5/07	Baltimo:	re, Maryland		
Baltimore,	permit. Page Department of Importent: If any Injury or once.		21. Signature of Funeral Service Licensee			•	oudon Par ., Baltim				
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		231 Ant Internal Between Onset and Death Shook, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. INTRACEREBRAL HEMATOMA  TOTAL ACTION AND AND AND AND AND AND AND AND AND AN								
		<b>1</b> 6	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence b. Due to (or as a consequence consequ		CERTIFICATION AS PROVED BY MEDICAL EXAMINA			Onset and Death  G-DAYS  NER			
Division or vital Records, P.O. Box 68/60,		Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events  c.								
		edical E	Due to (or as a consequence	or):							
		Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  23c. If yes, outcome pf pregnancy  1 □ Live birth 2 □ Fetal death  4 □ Pregnant at time of death	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				23d. Date Mor	e of delivery nth Day Year		
		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?  1			
		Completed						24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes 2   No   1   Yes 2   No			
		Be (	25. Was case referred to medical examiner?		la.		Death (Check only o				
		tion: To		utpatient Time of Injury							
		Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (S City or Tov	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
		edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	vithi Vomi	Me	29b. Signature and title of certifier  Neganolika. J, MD		29c. License number  RES Ø Ø Ø Ø			29d. Date signed (Month, Day, Year) SEPTEMBER 1 2007			
	(c)		30. Name and address of person who completed cause of death (Item 23a)  NAGA MALLIKA TASTI, HARBOR HOSPITA	(Type, P	rint)			11.5			
i ja	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 2 0 2007	3844	<i>'</i> \$						

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amend items 11 19b per inf 9874 12-11-07 vt
State of Maryland Prepartment of Health and Mental Hygiene
Amend Items 23a per me, 8873, 11/28/0/diplicate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month NO V Year **Physician** 6:25 PM 200 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore

Winder 1 Year | H Under 24 Hrs. | Min. Good Samaritan Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2X F 80 **Director** Maryland 214-22-6270 4-1-1927 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show donorman be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Whitehall Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5321 Broadway Road 21161 USA filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: the Mudical Exp. þ Specify: White 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify onfy highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any light yo or other traumatic event soins. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Herman Rehbein Mary Lemmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5321 **Broadway** Road Whitehall, MD 21161 Lisa Taylor (Daughter) 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holy Redeemer Cemetery 11-06-2007 Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee serols. 9705 Belair Road Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Cona. **Physician** RIPUEN /Medical **Examiner** a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ROVER BUTENCAL EXAMINER Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed after death. burial-transit CERTIFICATION Due to (or as a consequence of): Box 68760. physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death signed by the a 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions of optnbuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by as been signal 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page Division of Vital 1 Yes 1 Yes 2 No Be funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 ☐ Yes 2 No ۵ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funeral Director; Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mpleted cause of death (ftem 23a) (Type, Print) 30. Name and address of person who 31. Date filed (Month, Day, Year) Kave 32. Registrar's Signature NOV 2 8 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 20b, perFH, g874, 12/6/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 7 /Medical 4a. Facility Name (If not justitution, give street and number) Examiner County of Dea If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 9. Birthplace Country) **Funeral** Days Hours 1 M 2 F Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exa⊞iner must be notified at MD Baltimore 1XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5604 21239 USA Sagra Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (9-12) College (1-4or 5+) Social Security lains Examiner Years 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Crump torence Vuncent 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freda Crump 8402 Horatio Road Baltmore MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Greenmount Crematory 12/3/2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaughn C. Greene Funeral SVCS 21. Signature of Funeral Service Licenses ibem Readlandall Stown MD 21133 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on jach line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed burial-transit and P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed certificate 2 4 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural Injury 1 Tes 2 □ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Italy Year) 2. Registrar's Signati State 8 2007 Registrar

Maryland 21215-0036 Baltimore, 800388WN Records, Division or Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend isens of the Gland be said and and Mental Hygiene 1 = State amend item 2 per doc g875 1-3 CQ8tiNeate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** hristopher 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hartore Upper 5. Social Security Number Chesopeake Bel If Under 1 Year | If Under 24 Hrs. / Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**∑**(M 2□ F 213-41-1621 Director maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Bel Air 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1426 Banavie Terrace 21015 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10 College (1-4or 5+) Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray Cooper, Jr. Kimberly Fisher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1426 Banavie Terrace Bel Air, Ray Cooper, Jr. (Father) MD 21015 20b. Place of Disposition (Name of Highwey paramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 30 Fallston 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gar, 11-28-2007 Bel Air, Maryland 22. Name and Address of Facility  $Schimunek \ Funeral \ Home \ of \ BelAir$ 21. Signature of Funeral Service Licenses 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Adrena /Medical Due to (or as a consequence of): Examiner Adrenal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Panhypo burial-tran Due to (or as a consequence of as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 1 Yes 2\\\\_\(\)\(\)\(\) 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred tal or Attending F s after death. Medical Certification: 5 Pending investigation To the Hospital or Attenums within 24 hours after death.

To the Funeral Director: After the funeral Director of the funeral Director. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie morrec

State Registrar

31. Date filed (Month

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) main

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Day 2007 Month **Physician** 23, Nov. 1:00 P M Thressa A. Carter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 9504 Perry Hall Blvd. Nottingham

If Under 1 Year | If Under 24 Hrs.

Wonths Days Hours Min. Apt 202 Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 SF Director 234.46.6994 05.07.1930 WV Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Marel Hygiene. Important: If time Z'i san-Ked other than "natural", or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9504 Perry Hall Blvd. Apt. 21236 U.S.A. 202 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: White Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restuarant 10 Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill thent of Health and Mental Hisant: If item 27 is marked oth Be Frank Cryser Katherine Logan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Sobieck/Niece 8716 Baker Avenue, Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11.26.07 Beltsville, MD Chesapeake Crem. 21. Signafture of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto M01443 Ru <u>Alternatives 8717 Green Pastures Dr. MD</u> My Juk 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atheroselerotic Coronam Vascular years /Medical Due to (or as a consequence of): Examiner per cholesteral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (\*r as a consequence of): Examiner -transit requires that the death certificate be executed and Due to (or as a consequence of): burialphysician a the burial Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 🗷 No Month signed by the a Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown monom Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 24 No 24a. Was an certificate has autopsy performed page 20 No 2 No Division or Vital 1⊟ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

NOV 2 8 2007

BRAD FORD

30. Name and address of person wh



completed cause of death (Mem 23a) (Type, Print)



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Beloir Rd Batt, Mo

		For	State of Marylan	d / Depa	artment of H	lealth a	nd Me	ntal Hy	giene		
		1 - State Registrar		Ce	rtificate of	Death			Reg. No.	17	37854
Physici	ian	1. Decedent's Name (First, Middle, Last)	John Edward	Cactl	o Tr			Date of De	Day	Year 007	3. Time of Death 2:20 P M
/Medi Examir		4a. Facility Name (If not institution, give s		Caber	4b. City, Town, o	r Location of		O V Child	4c. County		2.20 F
Examil	iei	Laurel Regional Ho			Laurel				Princ		orge
Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2		Date of Birt	h	9. Birth	place (State or Foreign
Director		220-09-2298 1 <sup>1</sup> X	<sup>M 2□F</sup> 89	Yrs.	Months Days	Hours	Min. J	(Month, Da une 10	1918	<sub>Coui</sub> Mary	land
pu >		Usual Residence of Decedent  10a. State 10b. County	I 100 Cib	y, Town or Lo	antion						10.4.4
laryla shov	5				Caton						10d. Inside City Limits 1 ☐ Yes 2X No
be filed within 72 hours after death with the Maryland tal hygiene. do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	MD Prince Ge	eorge   La	urel	10f. Zip Code				10g. Citizen of W	hat Cau	
with a or			D 1							nat Coul	nu y :
leath ns 23 mus	Funeral	5810 Sandy Spring	ROAG 12. Was Decedent Ever in U.	S. 13.	20707 Was Decedent of H	lispanic Orig	in? (Specif	v Yes or No	U.S.A.	- Americ	can Indian,
of the contract of the contrac	F	1 □ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Was Decedent of H If Yes, specify Cuba		Puerto Rio	an, etc.)	Black	, White,	
al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🖾 No	Specify:			- Specify.	Whi	ite
72 hc natur fical	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	ation	of working		16b. Kind of Bu	siness/In	dustry
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be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name (F	irst, Middle,	Maiden Surnam	9)	
should Ind Men	မ	John Edward Castle		T 401 44 11				A. Baı			
c, wall yialio 21.2.  1 and 2 should be filed with: Health and Mental Hygiene. em 27 is marked other than ther traumatic event, the Me		19a. Informant's Name/Relationship (Typ	ŕ		ng Address (Street						,
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Pages Hent of H Int: If Ite		1 Burial 2 □ Cremation 3 □ R	emoval from State	emetery, crei	matory or other plac	í				•	
		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License			Cemetery  2. Name and Addre		ov 19	, 07	Laurel,	Mar	yland
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OLUSSIE.		23a. Part1. Enter the wheate, or complin	M007		13 Talbot					207	
Dhusisian		shock, or heart will be. List only on Immediate Cause Final	e cause on each line.			3,				-	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ		Arrest					-	
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cate be executed physician and the burial-transit	dical	<b>€</b> d	•								
ertifica ing pl	Med	IF FEMALE:									
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3	Ectopic pregnancy	,			23d. Date Mor		ery Day Year
the a	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	eath 5□	Other (specify)				Wiot	ICFI	Day Feat
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sicla certi	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)  Hospital: 1   Inpatient 27   FR/Outpatient 3   DOA   Other: 4   Nursing Home   5   Positions   6   Positi								
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th. : Afte	ţ	1 XNatural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?  M 1 Yes 2 No					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Atter r dea ector	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f.			r or Run	al Route Number,
al or all	erti	4 🗆 nomicide	building, etc. (Specify	/)				City or Tou	vn, State)		
bspit hours iners ly fille		29a. Certifier 1 Certifying Phys	Iclan: To the best of my know	wledge, deat	h occurred at the tir	me, date and	place, and	d due to the	cause(s) and ma	nner as s	stated.
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Medical	(Check only 2 Medical Examir one)	er: On the basis of examination and manner stated.	uon and/or in	vestigation, in my o	ppinion, deat	n occurred	at the time,	date and place, a	ind due t	o tne cause(s)
Vith Vith To t	Σ	29b. Signature and title of certifier			29c. Licens	e number			29d. Date signed	(Month,	Day, Year)
		D54223					11/16	107	,		
D		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type,	Print)				1	/	
10		Thuan Nguyen, M.D.			ad, Laur	el, Ma	arylar	nd 207	07		
Sta	ite	31. Date filed (Manth Pay Year) 2007	32. Registrar's Signa	ture	164.)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 3:10 P M 22, Charles Donald Calder November 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months M 2□ F Director 69 Oct. 16, 1938 219-34-4495 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Port Deposit Cecil 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21904 USA 80 Principio Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ould be filed within 72 hours after. Mental Hygiene. 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 2 📆 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Boiler Maker U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Hazel Wildason William E. Calder ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an 2019 Mardic Drive, Forest Hill, MD 21050 item 27 Tammy Vanarsdale / Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages Department of Important: If it any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Air Memorial Gdn: 11-27-07 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Liga 23a. Part 1. Enter the make, or complications that caused the shock, or heart in ure. List only one cause on each line. <u>50 W. Broadway, Bel Áir, MD 21014</u> Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to ( as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the as attending for use as 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of pertifier 0059855

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Registrar

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Registrar's Signature 31. Date filed (Month, Day, Year) .

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 18, perFH,g873, 11/28/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DIXON Month Physician. YRTLE 1030 A M NOVEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner Catonsville Baltimore Commons - Catonsvillo If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

8. Date of Birth (Month, Day, Under 1, Day) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219.38.6596 1 ☐ M 2 🛣 F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. As the wast. If Item 27 is marked other than "natural", or Items 23a or 28a-f show ant; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medic al Examiner must be notified at any or other traumatic event, the Medic al Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Roundview Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Black þ Specify: 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) entary/Secondary (0-12) Johns Hopkins Assistant Nurses 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Caple C.K. Lee Elsie Bennett ٩ 19a. Informant's Name/Relationship\_(Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) awford, 6708 Chishdm Drive Baltimore MD 21207 'Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Baltimone, MD Important: If any Injury o 30 07 Loudon 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughen C. Greene Fundral Services Jaughn 8728 Liberty Read Randallstron MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ISEASE ARKINSONS disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the bunal-trans Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760, Physician/Medical attending pt 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2☑No 3☐ Probably 4☐Unknown 1 Tyes page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral L 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 21649 NOVEMBER 26 2007

Registrar

DHMH 17 Rev 1/2001

State

WILKENS AVE BALTIMORE. MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMBANDAM

31. Date filed (Month, Day, Year)

NOV 28

BASKREAN.

32 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2007 Victor A. Defeo $2\overline{3}$ 11 8:43 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X** M 2□ F 89 219-05-4762 Director 11-11-1918 Maryland Usual Residence of Decedent a or 28a-f show t be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Director MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? e filed within 72 hours after death with all Hygiene. I other than "natural", or Items 23a or went, the Medical Examiner must be a 3 Brook Farm Ct 21128 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Brick and Stone Mason Contract n and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be es 1 and 2 should be fi of Health and Mental H f Item 27 is marked otl r other traumatic ever Michael Defeo Lucia Imperiale ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Defeo (wife) Brook Farm Ct Perry Hall, MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Morelan Mem'l Park 11-27-2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Aicensee 9705 Belair Rd Nottingham, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 51 Physician sears disease or condition resulting in death) /Medical Due to ( as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 2□No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6-Other (Specify) Hospital: 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Spice this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Division or Vital Records, P.O. Box 68760,

Attending Physician: filled in by the funeral death. within 24 hours after deatl To the Funeral Director: Hospital or completely

ပ္

State Registrar

Medical

determined

4 Homicide

29b. Signature and title of certifier

29a. Certifier

no

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) November 24, 2002

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701

and manner stated.

32 Registrar's Signature onth, Day, Year) NOV 2-8 2007 8

V. Charles St. Balts, Md 2,20%

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 37858 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Virginia B Doenges November 7 2007 8:29 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 5 1919 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 ☐ M 2 ☐ F 217 36 4939 88 Director Baltimore City, Md Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at Maryland Baltimore City Baltimore Y☐Yes 2☐No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3008 Christopher Avenue 21214 LISA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 X Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Housekeeping own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry R Nizer Jennie Marie Baver ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Carole A Ortt 8508 David Avenue Baltimore, Md. 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. November 10 2007 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service vicensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE TUBVIM NECROSIS wecks disease or condition resulting in death) Riffiel Parky /Medical his fractike Examiner WELKS complications Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events PROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of) that the death certificate be executed physician and is the burial-trans resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical CERTIF attending p IF FEMALE: ed by the attendin detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4□Pregnant at time of death 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2**X** No page 2 should 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy rmed? 1□ Yes the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner?
1 XYes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Mother (Specify) WOSPLY ဥ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury OCTOBER 25 2007 UNENGEN M 1 ☐ Yes 2 X No Fall in 2 Accident bathroom 6 Could not be determined 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 2100 Rossville BIVD, nome BALTMORE MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 58303 November 8 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Chales ST TONEN MD Ageon I cHARIES M 31. Date filed (Month, Day, Year) NOV 2 8 2007 32. Registrar's Signature Goard's State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiena 37859 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** NOVEMBER 21, 2007 9:30 PM DORN ARTHUR RADCLIFFE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mont. County Hospice of the Chesapeake
5: Social Security Number | 6. Sex | 7. Age (In vrs. last birtho Ft. Washington If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 60 Director 144-34-8255 4/19/47 NJ Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. fnside City Limits 10h County worle Atlantic Atlantic City 1 Yes 2 No Completed by Funeral Director NJ 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number WITH Dr. Martin King 08401 USA 720 N. Rev. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces:

1 X Yes 2 No
If Yes, Give VIETNAMYear or Dates: —ERA Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene.
Int: If Itam 27 is marked other then "naturel", or iter into or other treumatic event, fire Medical Examinarity or other treumatic event, fire Medical Examinarity 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) City Water Repairman 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James R. Dorn Eva Dorn ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 720 N.Rev. Dr. M. King, Atl. City, NJ 08401 Gene Dorn/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important; if Its eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Estell Manor, NJ Atl. County V.A. 11/30/07 22. Name and Address of Facility Pari P. Close F. 21. Signature of Funeral Fervice L 5126 Belair Rd, Balt., MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** CIRRHOSIS OF THE LIVER /Medical Due to (or as a consequence of) Examiner HEPATITIS C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9☐ Unknown 9 🗍 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: 1 Yes 2X No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospic 6 1 ☐ Yes ≥ No ۵ 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Am B MD# 33255 NOVEMBER 23, 2007 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) KAREN ANN BLACKSTONE, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year) 32 egistrar's Signature State NOV 2 8 2007 Registrar

		•	State of Maryland / De State of Maryland / De	partment of Healt 04/08/08dhbea ertificate dhbea	th and Mental Hyg ath	giene UU / 3 / 00 I								
<u>.</u>			1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year 3. Time of Death								
	Physicia /Medic		Robert D. Epstein		Novembe:									
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Local		4c. County of Death								
			Vantage House	Columb	D1.a Inder 24 Hrs. 8. Date of Birtl	Howard  9. Birthplace (State or Foreign								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hou	ours Min. O6/11/	9. Birthplace (State or Foreign Country) Tennessee								
24	Director	1	Usual Residence of Decedent											
	yland		10a. State 10b. County 10c. City, Town of			10d. fnside City Limits 1 ☐ Yes 2X No								
	Mar a-fsl	ctor	Maryland Howard Co	olumbia										
	or 28	)ire	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?								
	23a	Funeral Director	5400 Vantage Point Road	21044	4 ic Origin? (Specify Yes or No-	USA 14. Race - American Indian,								
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21215-0036	2 hou	ted		ecedent's Usual Occupation Give kind of work done during	a most of working	16b. Kind of Business/Industry								
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2	ed wil	Completed	5 <del>+</del>	Physician	Mother's Name (First, Middle,	Self Employed								
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<u> </u>	d Mer nark	7	Jacob Epstein  19a. Informant's Nama/Relationship (Type, Print)  19b. 1	Mailing Address (Street and N		er, City or Town, State, Zip Code)								
Maryland	d 2 s th an t7 is r traur					Lacksburg, VA 24060								
ā,	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Medical Evertires must be notified at		20b. Place of D	Disposition (Name of crematory or other place)	Date	20c. Location - City or Town, State								
9	Pages nent of nnt: If its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)  Metro	Crematory Inc.	. 11/26/07	Baltimore, Maryland								
Baltimore,	그 문원을 .		21. Signature of Funeral Service Licensee	22. Name and Address of	Facility Of Maryl	and. Inc.								
Ö	Depa Impo any is	11 7	Thomas Gregor	299 Frederick	k Road Baltimo	and, Inc. ore, Maryland 21228								
4	v		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, su	uch as cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death								
	Physician		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):											
	/Medical Examiner		Due to (or as a consequence of	):										
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8760,	cate be explored by sician the burian	cal												
Ö		ed	IE CENAN E.											
Вох	eath certific attending p i for use as i	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery  Month Day Year								
о. В	at the dea by the at tached fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)										
<u>α</u>	hat the		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in	Part I. 23e. Did	tobacco use contribute to the cause of death?								
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Re	The lay	dmo			auto perfe 1 ☐ Yes	psy prior to completion of cause of death? 2 No 1 Yes 2 No								
tal		CO	25. Was case referred to medical	26.	Place of Death (Check only	7.								
<u> </u>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4	4 X vursing Home 5 ☐ Res	idence 6 □Other (Specify)								
ιof			27. Manner of Death 1 SAutural 5 Pending 28a. Date of Injury (Month, Day Year) In	jury Work?		how injury occurred								
Sio	Attending or death.	atic	2 Accident investigation		2 No	(Carach and Number or Bural Bouta Number								
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjury - At home, far building, etc. (Specify)	m, street, factory, office	28t. Location (	(Street and Number or Rural Route Number, wn, State)								
	urs al arel D		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time of	date and place, and due to the	cause(s) and manner as stated.								
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and and manner stated.	/or investigation, in my opinio	on, death occurred at the time	, date and place, and due to the cause(s)								
	To the To the comple	Me	29b. Signature and title of certifier	29c. License nu	umber	29d. Date signed (Month, Day, Year)								
	->-0		1/1 2	- DIT	425	11/23/07								
	6		30. Name and address of person who completed cause of death (Item 23a) (	Type Print)		11/23/07 W cotarsville ul								
	7)		Wille B. N.VEUBAND 41	3 commo	weath &	w Cotarsville all								

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 7 37862 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year KLING 1:16 PM NOV 25 2007 4c. County of Death
HOWARD COUNTY GENERAL HOSPITAL COLUMBIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min Hours 1 M 2 □ F 75 219-28-3470 Dec. 3, 1931 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21075 United States 6716 Cozy Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 152-155 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Federal Government Customs Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert I. Forsht Evelyn Kling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beth Forsht / Dau. in Law 4600 Sutton Oaks Dr., Chantilly, Virginia 20151 Date 29 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 2007 Metro Crematory, Inc. Catonsville, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A.
421 Crain Hwy., S.E., Glen Burnie, 21. Signature Juneral Service MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMON Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 Yes 2 No investigation 2 ☐ Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

/Medical Examiner

**Physician** 

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

r than "natural", or Items 23a or the Medical Examiner must be

Director

Funeral

Completed by

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death with the Maryland

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permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr

Pages 1 and 2 should I

Maryland 21215-0036

Baltimore,

death certificate be executed sician and burial-trans physician s the burial attending ph P.O. signed by Vital Records.

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Division

certificate has be irector, page 2 s After this certific funeral director, Hospital or Attending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi

Physician/Medical

Examiner

Completed by Be ပို

4 Homicide

29a. Certifier (Check only one)

Certification:

Medical To the I within 2. 4

State Registrar 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number INTENSIVE CARE PHYSICIAN DUOGUSG3

29d. Date signed (Month, Day, Year) NOV, 25, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMED ALATTAK
HOWARD (SUNTY GENERAL FOSPITAL
57.55 CEDAR (AWE)
31. Date filed (Month, Day, Year)
32. Hegistrar's Signature

29b. Signature and title of certifier

goods?

and manner stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn Peter Figlar		State of Maryland I-For State Registrar	/ Departme Certifica			and	Mental Hy		g. No.	200	7	37	86
Physicia Medical Examin	n/	Decedent's Name (First, Middle,Last)	Datas Fiels					Date of Deat     Month     November	h		3. Tim	ne of Deat	
		4a. Facility Name (if not institution, give street and number	eter Figla			, or Lo	ocation of Death	November	4c. Cc	ounty of Death			
Funeral		177-Old Englewood Road Days Inn R 5. Social Security Number 6. Sex 7. Ac	m. 19 ge (In yrs. last birth	nday)	Easton	Year	If Under 24Hrs	8 Date of Birt	Talk		rtholace	State or	Foreign
Director		284–34–2563 <sub>1</sub> X <sub>M 2</sub> <sub>F</sub>	68	Yrs.	$\overline{}$	Year   If Under 24Hrs.   8. Date of Birth (MM/DD/YYYY)				Co	Ohic	)	- Oreign
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Locatio	on						10d.	Inside City	Limits
<b>*</b>	5	MD Talbot	E	asto	n							Yes 2	No
S Anary or 28a-	Director	10e. Street and Number 177 Old Englewood Road	-		10f. Zip Cod	de 601		11		of What Cou	-		
with the ms 23a		11. Marital Status 12. Was Deceden	t Ever in U.S.	13. Was			anic Origin? ( Sp	ecify Yes or No		. Race - Amer			k,
r death	Funeral	1 Never Married 2 Married 1 Armed Forces 1 X Yes 2	2 No				Mexican, Puerto	Rican, etc.)		White, etc.	: + 0		
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-003 I within giene. fher the	e e	17. Father's Name (First, Middle, Last)		Sen	ior Pl		ner 3.Mother's Name	(First Middle I	L	ntertai	Lnme	nt	
21215-0036 and be filed within 7 Mental Hygiene. marked other than marked other than	Be C	LeRoy Otis Figland											
D 21 should and Me 7 is ma	유	19a. Informant's Name/Relationship (Type, Print )			•		and Number or I					ode)	
e, MD I and 2 sho Health and item 27 is	ŀ	Lee Figland, Brother  20a. Method of Disposition	20b. Place o	f Disposit	tion (Name o		etery, H	Date		cation - City or		State	
Pages lent of ant: If		Burial 2 X Cremation 3 Removal from S  Donation 5 Other Specify:	3 Removal from State crematory or other place)  Philadelphia Crematory 11/29/2007 Philadelphia								nia,	PA	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f should yor other traumatic event, the Medical Examiner must be notified at once.	-	21 malure LE neral Service Licensee MO	3				of Facility Hin Avenue,						е
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									App	oroximate tween Ons	
/Medical :aminer		Immediate Cause (Final disease a. Cirrhosis (									1	Death	
		or condition resulting in death)  Due to (or as a consequentially list conditions,  b.	sequence or):										
	Examiner	if any, leading to immediate Due to (or as a conscause. Enter Underlying Cause	sequence of):										
agi. Her	Exal	(Disease of injury that initiated events resulting in death) Last  Due to (or as a cons	sequence of):										
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Box 6876( ne death certificate the attending phy ned for use as the back.	iciar	past 12 months?  4 Pregnant a	at time of death 5		al death ner (Specify)	3 _	Ectopic pregna	ancy	M	onth	Day	Ye	ear
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ords, w requir	lete(							24a. Was		24b. Were a		findings a	
Recol	Completed								rmed?	death?		2	No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	ient 2 ER/O	utpatient		10	of Death (Check	only one) ng Home 5	Davidana	ce 6 🗸 Oth	C		
n of Vi	٤	27. Manner of Death 28a. Date of In	jury 28b. <sup>-</sup>	Time of In			at Work?	28d. Describe			er. Ster		
tendir Jeath. Tor: A	턇	1 X Natural 5 Pending Investigation	, real)		1	Ye	es 2 No				- T		
Divisi pital or Att ours after d ceral Direct filled in by	ertification:	3 Suicide 6 Could not be determined (Specific)	Injury - At home, fa	rm, stree	t, factory, of	fice bu	ilding, etc.	28f. Location ( or Town, S		Number or R	Rural Ro	ute Numb	er, City
hor hor	ㅇ ŀ	4 Homicide (29a. Certifier (Check only 1 Certifying Physician: To the best of r											
To the Hos within 24 h To the Fus completely	Medical	one) 2 Medical Examiner: On the basis of examiner stated	amination and/or in	nvestigati				at the time, date					
	2	29b. Signature and title of certifier				cense ).C.M	number 1.E.			ite signed <i>(M</i> mber 16, 2		ay, rear)	
b	}	30. Name and address of person who completed cause of	death (Item 23a)										
-0		Pamela E. Southall, MD Assistant Med		r 11	1 Penn St	reet,	Baltimore, I	MD 21201					
Sta Registi	~	31. Date filed (Month, Day, Year) 2. Registr	ar's Signature	back									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		Ce	ertificate of	Death		Reg. N. 200	17 3/864
ľ	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	3. Time of Death
	/Medic	al	Robert F. Gately	- 44>		45 Oit Town	- Loophing of Dooth	//	24 200	
	Examin	er	4a. Facility Name (If not institution, give street as Good Samaritan Hospit			Balti	r Location of Death		4c. County o	Death
*	Funeral Director		5. Social Security Number 6. Sex 1 M 2 [	7. Age (In yrs. 70	last birthda Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 12–16–19	r, Year)	9. Birthplace (State or Foreign Country) Maryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or	Location			-	10d. Inside City Limits
	e Mary a-f sh iffied	ctor	Maryland Harford		Edge	wood				1 ☐Yes 2X No
	or 28 be not	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
	eath v is 23a must	Funeral	1956 Steven Rd	Decedent Ever in III	e 15	21040	lienania Origin? (Sr		U.S.A.	- American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		_ If Ye	s Decedent Ever in U ned Forces?  Yes 2 [X]No es, Give Ir or Dates:	.0.	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Specify:	Rican, etc.)	Black Specify:	, White, etc.
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121	within ene. than '	Completed by	Elementary/Secondary (0-12) Coll	lege (1-4or 5+)	l	. DO NOT use retire Tright	d)	1	Beth Ste	ee1
<b>d</b> 2	e filed Il Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)		1		18. Mother's Nam	L		
ylar	ould be Menta arked	면 일	Robert W. Gately				Margare	t M. Rip	ple	
Maryland	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (Type. Prin		1	iling Address (Street			-	State, Zip Code)
	is 1 and 2 of Health a item 27 is		Mary D. Will (Daughter 20a. Method of Disposition			Prindle I position (Name of rematory or other pla		Date Date		City or Town, State
Baltimore,	i. Pages tment of tant: If i		1 XBurial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)		1 Air	Memorial	Gar. 11-2	9-2007 E	Bel Air,	Maryland
Bal	permii Depar Impor any Ir		21. Signature of Funeral Service Licensee		11	22. Name and Addre  Inc. 610 V	50			Home of Bel Air MD 21014
L		8	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	e on each line.						Approximate Interval Between Onset and Death
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ecc	2 8 8	Completed						24a. Was autop	osv p	Vere autopsy findings available fror to completion of cause of leath?
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<b>=</b>	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital	: 1 ☐ Inpatient 2	ERVOutpati	ient 3 DOA Oti	26. Place of Dea		<i>fie)</i> dence 6 □Othe	or (Specify)
o uo	The The		1 Natural 5 ☐ Pending	. Date of Injury (Month, Day Year)	28b. Time Injun	of 28c. Inju			now injury occurre	
Division or Vital Records,	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	- Cauld not be	Place of injury - At h building, etc. (Speci	ome, farm,			28f. Location (S City or Tou		er or Rural Route Number,
	e Hospit 24 hours e Funera letely fille	Medical C	29a. Certifier Certifying Physician: (Check only 2 edical Examiner: Or one)	To the best of my known the basis of examination manner state.	owledge, de ation and/or	eath occurred at the t investigation, in my	ime, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and mad date and place, a	nner as stated. and due to the cause(s)
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			Jeny Con	N	10	1958	933		Novem	be-24,2007
			30. Name and a drest of person who complete	d carse of death (Iter	m 23a) (Typ	e, Print)	2.1-21		25.15	77
	Ψ Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign	aArre /	parle	DON D. PT	all imor	-E,MD 2	21238
	Registi		NOV 2 8 2007	Marie d	J 1	800				

Robert Gately

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Ruth Elizabeth Gleason Nov. 20 .2007 11:12P<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore FUnder 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 M 03.21.1906 Director 577.10.1771 101 DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? tems 23a or 4914 Canvasback Drive U.S.A. 21045 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1. Never Married 2 Married or / い / (1:13 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ρ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than " Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Federal Government 12 Clerk Pages 1 and 2 should be filed in nent of Health and Mental Hygic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nettie Gertrud Wilburn ပ Parick Joseph Gleason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health at Important; If Item 27 is any Injury or other trau Patricia Simmons/Niece 4914 Canvasback Dr., Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 11.24.07 | Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation And Funeral Balto W101442 Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician END STage 1 year resulting in death) /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duie to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day 5 Other (specify) by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an has certificate has irector, page 2 autopsy performe 1□ Yes 2□00 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Steller (Specify) NOS pice 1 ☐ Yes 2 🔀 🕽 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Division or After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 6 Could not be determined 3 Suicide 28e. Płace of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Pwithin 2

State Registrar 30. Name and address of person who completed cause of death (item 26a) (Type, Print) tzage

2007

Year)

8

NOV 2

29b. Signature and title of certifier

31. Date filed (Month, Day,

Street 32 Registrar's Signature

29c. License numbe

29d. Date signed (Month, Day, Year)

		,	1 - State Registrar		State of	iviai yiai		rtificat			u ivie		Reg. No	/ 1111	7	37	866
	Physicia	an	Decedent's Name (Fig.	rst, Middle, Las	,						2	. Date of De Month	Da	ay	Year		e of Death
	/Medic						Gearha					Novemb	er	21, 2	007	10:	45 P M
	Examin	er	4a. Facility Name (If not	_	street and numb	ber)				ocation of D	eath		40	c. County o	f Death		
			Harmony Ha  5. Social Security Numb		ev 7	. Age (In yrs.	last hirthday		Lumbia	a. If Under 24	Hrs.   g	. Date of Bir	Howard 0 R			alana /Ctr	ate or Foreign
l	Funeral Director		470-16-431	8 1	□M 2 <b>∏</b> F	89	Yrs.	Months	Days		Vlin.	(Month, Da Sept 5	ay, Year	/	Cour	esot	
	land			o. County		10c. Cit	ty, Town or Lo	cation							1	0d. Insid	e City Limits
:	Mary Fied (	호	MD H	oward		Co	lumbia									1点	Yes 2 □ No
-	r 28a r 78a	irec	10e. Street and Number					10f. Zip	Code				10g. C	itizen of Wi	hat Cour	ntry?	
13	th wit	alD	6336 Cedar	Lane #	364			210	044			1	U.	S.A.			
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inportantent of Health and Mental Hygiene. Inportant: If tien Z7 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral Director	11. Marital Status 1 □ Never Married		12. Was Deced Armed Ford 1  Yes 2 If Yes, Give	es? ! 💢 No		Was Deced If Yes, spec 1 ☐ Yes		panic Origin , Mexican, P Specify:	? (Specif uerto Ric	y Yes or No can, etc.)	0-	14. Race Black, Specify:	- Americ , White,		Ι,
3	ural",	d by	3 🔯 Widowed 4 🗆		Year or Dat	es:				1					Whi		
2	"nat	Completed	(Specify o	Decedent's Ed only highest gra	lucation de completed)		(Give	dent's Usua kind of wor DO NOT us	rk done du	ion Iring most of	working		9	Kind of Bus ited			
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י אינויייייייייייייייייייייייייייייייייי	Hygin Hygin		17. Father's Name (Firs	t, Middle, Last)			Dicci	-1 01111		18. Mother's		First, Middle	, Maide	n Surname	)		
5	lid be lental ked (	To Be	Edward Lou:	is Scha	efer				.	Laura	Ouir	nn					
, E	shou and M amar umat		19a. Informant's Name/	Relationship (	Type. Print)		19b. Maili	ng Address		nd Number o	~		er, City	or Town, S	tate, Zip	Code)	
	alth a 27 is		Geraldine 1	L. Zarb	o /daug	hter	8205	Moss	sy Sto	one Ct	. La	urel,	Ma	rylan	d 20	723	
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	Page nent int: If		1 ☐ Burial 2 🗓 Cr 4 ☐ Donation 5 ☐			W.	Arund	el Cr	emato	ry No	v 24	, 07	Od∈	nton,	Mai	rylaı	nd
	permit. Departr Importa any Inji		21. Signature of Funera	al Service Licen	See1	M007	773	2. Name an	d Address	of Facility Funera t Ave.	l Ho	ome, P	.A.	url nn d	207	07.4	200
			23a. Part1. Enter in di shock, or heart rai	se se or com	olications that car									yrand	207		mate Between
P	hysician		Immediate Cause (Fig.	lure. List only												Onset a	ind Death
	/Medical		disease or condition resulting in death)		м.	r as a conseq	nal Ins	ullic	rency	Y					-	3 ye	ars
E	Examiner		Sequentially list conditions, target to nonaparts b. Cardiomy or athy												3 ye	are	
		ner	Sequentially list condition	ons,	0.									-		<u> </u>	di b
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	rincate be executed by physician and as the burlal-transit	Medical			d. Coron	ary Ar	tery D	ıseas	se						_	3 ye	ars
		/Me	IF FEMALE:		23c. If yes, outco	ome of pregna	ancv							02d Data	of dollars		
	The nospiral or Attending Prysician: The law requires that the death cert in 24 but or stiffer death.  The Funeral Director: After this certificate has been signed by the attendin higherly filled in by the funeral director, page 2 should be detached for use.	Physician/N	23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	ths?	1☐Live bir	th 2□Feta nt at time of c	al death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>						23d. Date Mont		Day	Year
9 4	rnar led by deta		Part II. Other significan	t conditions o	ontributing to dea	th but not res	ulting in the u	nderlying ca	ause given	in Part I.		23e. Did t	tobacco	use contrib	oute to th	ne cause	of death?
3	n sign	d by										1 🗆	Yes 2	2 □ No 3	B Prob	ably 4	X]Unknown
	s been si	lete										24a. Was	an	24b. W	ere auto	psy findir	ngs available
	te has age 2:	Completed									_		ormed?	de	ath?	mpletion ∈ 2 🄀 No	ngs available of cause of
	certificate ector, pag	Be C	25. Was case referred t	o medical						26. Place of	Death (0	1□ Yes Check only o	2 🔯 N one)	0 11	Yes	241 NO	-
	ysic lis ce direc	To B	examiner? 1 ☐ Yes 2 💢 No		Hospital: 1   Inj	patient 2	ER/Outpatier	nt 3 🗆 DO	Othor			5 ☐ Resi		6 XIOther	(Specifi	v/Ass	isted
) å	ding Proystctan: The Tr. After this certificate ha funeral director, page		27. Manner of Death 1 ☑ Natural 5	☐ Pending	28a. Date of	Injury Day Year)	28b. Time o Injury	f 2	8c. Injury a			d. Describe					ving
	ending auth.  or: All he fu	atic	2 Accident	investigation				M		es 2 □ No							
	afor Am after de I Direct d in by t	Certification:	3 Suicide 6 4 Homicide	Could not be determined	20e. Place o	f inju <b>ry - A</b> t ho g, etc. <i>(Specil</i>	ome, farm, str	eet, factory	, office		28f	Location ( City or To	Street a wn, Stat	nd Number te)	r or Rura	i Route f	Vumber,
Henele	vitin 24 hours after death.  To the Funeral Director: /	Medical C	29a. Certifier 1 🔀 (Check only 2 🗆	Certifying Ph Medical Exan	ysiclan: To the base niner: On the base and manne	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the time , in my opi	e, date and p nion, death	occurred	d due to the at the time,	cause( , date ar	s) and man nd place, ar	ner as si	tated.	se(s)
40	Mithin Sompl	Me	29b. Signature and title	of certifier	. 1		Δ	29c	. License r	number	-		29d. Da	ate signed	(Month,	Day, Yea	ır)
·	0		> ADI	o do	XLI I	PARI	1 11:	D. D	43323	3			Nov	ember	- 23	. 201	0.7
	6		30. Name and address	of person who	completed cause	of death (Iter	n 23a) (Type,	11.								, 201	
1	2		Abeda Ali				ckory	Ridge	Road	l, Col	umbi	a, Ma	ryla	nd 21	044		
	Sta Registr		31. Date filed (Month, D	ay, Year)	32. Reg	gistrar's Signa		ask I									

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Division or Vital Records, P.O. Box 68760,

Patienk

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Philley

DHMH 17 Rev 1/2001

29c. License number

RF5-000

29d. Date signed (Month, Day, Year)

2007

and manner stated.

32. Reditrar's Signature

Estar.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 22 5:30 A M 2007 Eugene Griffith Glazebrook November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll Dove House If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
March 31,1931 Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 15 M 2 ☐ F 76 Director 231-34-8343 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Director Columbia Maryland Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21044 5811 Barnwood Place death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16b. Kind of Business/Industry Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Salesman Automotive Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be fi Health and Mental I-Mell Janet Griffith Raynold Collier Glazebrook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trau 5811 Barnwood Place Columbia, MD 21044 Thelma Glazebrook (Wife) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory 11-27-2007 Catonsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral-Service L Inc Columbia, MD 21045 Musgay Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one out on each life. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed -trar and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an las l autonsy page performed? res 2⊒No certificate 1 Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 to ther (Specify) 2 No 1 Tyes 2 ER/Outpatient 3 DOA To the Hospina. ... within 24 hours after death.

To the Funeral Director: After this of the Funeral directory. 10 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check on and manner stated 29d. Date signed (Month, Day, Year) 29b. Signatu 29c. License number

State

Registrar
DHMH 17 Rev 1/2001

30. Name and address of person who

NOV 2 8 2007

Flavio Krute
31. Date filed (Month, Day, Year)

32. Registrar's Signature

Couter Street Westminster, MD21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 15.32 PM Michael Kerry Hannon NOV 25 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1X M 2□F 58 220-48-6913 June 8, 1949 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Francisco. 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County 1▼Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4404 Forest View Ave. 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 💢 No Specify Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Rebar Detailer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Edward Hannon, Jr. Elsie Lee Ammenheuser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4404 Forest View Ave Baltimore, Maryland 21206 Patricia Hannon (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 11-29-2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Ligenspee 9705 Belair Rd. Nottingham, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav been signed by the should be detached 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by METHICILLIN RESISTANT STAPHYLOCOCCUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an DIABETES BACTELEMIA has 1□ Yes 2 X No 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🕱 Inpatient 2 ER/Outpatient 3 DOA Certification: To o 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Director: After (Month, Day Year) or Attending 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral L 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar ZUBAIR SHAIKH, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE, MD-21239

M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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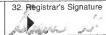
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month usen 25 200 /Medical Facility Name (If not institution, g 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore MI Hospita Maryland Greneral If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex yrs. last birthday, **Funeral** Days 1 □ M 2 📉 Hours Year) Director 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner πust be notified at 1 Yes 2 No altimore Director Nury and Number 10g. Citizen of What Country? 10f, Zip Code Funeral Vas Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Never Married 2 ☐ Married Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informant's Name/Relationship (Type. Print)(SiSter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jarren Mrs. Hugustine Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗹 Burial 2 ☐ Cremation 3 ☐ Removal from State Dundaik, 12/1 5 Other (Specify) of Facility 21. Signatu o Funeral Service License 1222 W. North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician is a consequence of): disease or condition resulting in death) /Medical to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🔲 Yes 2 No 3 ☐ Probably Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes P 1 Inpatient 2 NER/Outpatient 3□ DOA this within 24 hours after open...

To the Funeral Director: After thir 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NOV 30. Name and addres of person 31. Date filed (Month 2 Registrar's Signature Year State NOV 2 2007 8 Registrar

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State Registrar 31. Date filed (Month, Day, Year) NOV 2 8 ZUU/



Forest Hill MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 8876 2-16-08 yt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)Milton Henry aka Claude Milton Henry Day Physician 2007 Milton menry Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center

5. Social Security Number | 6. Sex | 7. Age (In yrs Baltimore Towson If Under 1 Year 9. Birthplace (State or Foreign Country)
N.C. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Yrs. 02.19.1919 Director 88 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be provided once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Lutherville-Timonium **Funeral Director** MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 12246 Roundwood Rd. #206 21093 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Ayes 2 No If Yes, Give Year or Dates: WW 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Textiles Executive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vida Blackman ပ Claud S. Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12246 Roundwood Rd. #206, Lutherville 19a. Informant's Name/Relationship (Type. Print) <u>Martha Henry/</u>Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Bunal 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 11.27.07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityCremation And Funeral Balto 21. Signature of Funeral Service Licensee M01443 Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician Mentas 6ASTRIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated even in the cause (Disease or injury that initiated even in the cause (Disease or injury that initiated even in the cause (Disease or injury that initiated even in the cause of the Due to (or as a consequence of) Examine attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 100 1☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NO.5 Pt 4 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral I 29a. Certifier transcritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 58303 November 26 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 78450× m 21204 6701 N. Charles ST J CHANGES UM AARON

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Derrick J. Hamm Nov 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore Citu Hospital Dinai N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X**☐M 2☐F 23 Director 11/27/83 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 922 E. Patapsco Ave 21225 USA 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married African American 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced "natural", or than "natura the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Construction Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other the amportant: If item 27 is marked other the ampiniury or other traumatic event, the 1 one. Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence E. Hamm Grace N. Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Green/Aunt 922 E. Patapsco Ave, Balt., MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 11/26/07 Balt., Bayview Crematory 22. Name and Address of Facility
Hari P. Close F. 21. Signature of Funeral Service Lice Svs, P.A 5126 Belair Rd, Balt., MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Embolism Physician monar /Medical Due to (or as a consequence of): Examiner ardiomyb Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue to (or as a consequence of): Examine Alcoho Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performe 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Many of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Box 68760, Ö Records, P. ór Vítal

Smith

Patient

Baltimore, Maryland 21215-0036

be executed physician and s the burial-trans has certificate Physiclan: After Division or Attending death. Hospital

attending pl within 24 hours after death

To the Funeral Director:
completely filled in by the

29b. Signature and title of certifie

3 Suicide 4 Homicide

29a. Certifier

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

State Registrar

Medical

Dirmarsico edus 32. Resistrar's Signature 31. Date filed (Monti

Sinai

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 28c-e, perME, g874, 12/3/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200 7 BRUCE **Physician** /Medical 4c. County of Death Pacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** VAMEdiCAL SALTIMORE BA HIMORE NIA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral** Days Hours APR 29 1949 58 Pennsylvania Director 207-36-6071 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Randallstown **Baltimore** death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 15 Cedar Hill Road 21133 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1968-71 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. δ Specify: 3 ☐ Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meaonee. Elementary/Secondary (0-12) College (1-4or 5+) Soldier U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward H. Holzer Helen Marsalek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Jeffrey H. Holzer - brother 15 Cedar Hill Road, Randallstown, MD 21133 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 11/27/2007 | Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liesuseeven H. Williams Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MUCOUS Due to (or as a consequency of): /Medical Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed physician and s the burial-trans APPROVED EN Due to (or as a consequence of): Box 68760, CERTIFICATIO Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has be irector, page 2 s autopsy perform 2 No 1∐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? unk 27. Manner of Death To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28d. Describe how injury occurred Subject in 5 Pending investigation 1 Natural Motor Vehicle Heldent 1972 unk 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide unk. Anchorage, unknown 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of confifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

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2007

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

10NO BHG

32. Registrar's Signature

GREENE STREET BALLIMORE MD 21201

07-09025

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

David Alan Heller	State of Maryland /	Department of I	Health and Mental H	_	200	7 2707
Physician	Registrar  1. Decedent's Name (First, Middle,Last)	- Continuate on I		Reg. 2. Date of Death Month D		3. Time of Death
Medical Examine	DAVID ALAN  4a. Facility Name (if not institution, give street and number)		HELLER City, Town, or Location of Death	November 2	2, 2007	1210 hrs
	11200 Belair Road		Nottingham		Politimore Cou	nt.
Funeral	5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	. 8. Date of Birth(	MM/DD/YYYY) 9. Birt	hplace (State or WASHINGTON, untry) D.C.
Director	215-15-9645 1X M 2 F	38 Yrs.	Months Days Hours Min	10/11/	1969 Cou	untry) D.C.
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Locatio	n			10d. Inside City Limits
* . l	MD N/A	BALTIMORE				1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once,	10e. Street and Number		10f. Zip Code	10g.	. Citizen of What Cour	itry?
r death with the Maryland or items 23a or 28a-f sh must be notified at once	4313 LaSalle Avenue	Ever in U.S. 112 Wee	21206 Decedent of Hispanic Origin? ( Sp	posifu Vos er No	USA	can Indian, Black,
leath w	1 X Never Married 2 Married Armed Forces? 1 Yes 2		s, specify Cuban, Mexican, Puerto		White, etc.	carringari, black,
s after d	Widowed 4 Divorced if Yes, Give Year or Dates:	1	res 2 X No specify:			HITE
5-0036 ed within 72 hours afte bygiene. other than "natural", he Medical Examiner Compuleted by		during mos	s Usual Occupation (Give kind of st of working life. DO NOT use ret		6b. Kind of Business/I	ndustry
5-0036 cd within 72 hour tygiene. other than "natu he Medi-il Exar	1	·	EMPLOYED		ART1	ST
215-0036 be filed within 72 hours after death with the Maryland mat Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Ba Completed by Funeral Director		NE. LE		(First, Middle, Mai	· · · · · · · · · · · · · · · · · · ·	ITRECC
MD 2121; 42 should be fill th and Mental h 127 is marked To Be	ALAN R  19a. Informant's Name/Relationship (Type, Print )	HELLES 19b. Mailing	R SANDRA Address (Street and Number or	Rural Route Numbe	er, City or Town, State	TRESS
MD and 2 sho sifth and m 27 is a marti	JANE HELLER / GRANDMOTHE	R 1121 UI	NIVERSITY BLVD.	WEST #1	12. SILVER	SPRING MD
2 E 2 E 2	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from Sta		on (Name of cemetery, er place)	Date 2	20c. Location - City or	Town, State
Baltimore, permit. Pages I at Department of Her Important: If ite injury or other tr	Donation 5 Other Specify: 21. Signature of Funeral Journal of Specify:		WISH CENTER 11/2 me and Address of Facility			
Balti permit. Departn Import	Cety M. No mena		3900 REISTERSTO		NSON & BRO	
Physician	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter the	e mode of dying, such as cardiac of	r respiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
/Medical caminer	Immediate Cause (Final disease a Asphyxia					Death
	or condition resulting in death)  Due to (or as a conse  Sequentially list conditions,  b.	quence or):				
iner		quence of):				
ted Insit	events resulting in death) Last Due to (or as a conse	quence of):				
and and	MENDER OF AMENDER OF THE STATE					
sici sici		a-f. perME.G875	. 1/7/08 TT		23d. Date of deliver	<u></u>
). Box 6876, the death certificate by the attending phy ched for use as the Physician/Me	23b. Was decedent pregnant in the past 12 months?	2 Feta	Il death 3 Ectopic pregn	ancy	Month I	Day Year
Box e death c the atten ed for us	1 Yes 2 No 9 Unknown g Unknown	time of death 5 Oth	er (Specify)			
ires that the signed by the detache		but not resulting in the un	derlying cause given in Part I.		acco use contribute to	
ision of Vital Records, P.O. Box 6876. Attending Physician: The law requires that the death certificate rideath. retor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the bication: To Be Completed by Physician/Mication:				24a. Was an		utopsy findings available
Records, The law require, ficate has been sig. gage 2 should be	· · · · · · · · · · · · · · · · · · ·			autopsy perform	prior to death?	completion of cause of
tal Rectian: The certificate ector, page			26.Place of Death (Check	1 ✓ Yes 2 only one)	No 1 Y	es 2 No
Division of Vital Records, ral or Attending Physician: The law requirr starter death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be artification: To Be Completed		nt 2 ER/Outpatient	3 DOA Other Nursi		esidence 6 🗸 Othe	
n of ding Ph. After t funeral	27. Manner of Death 28a. Date of Injur (Month, Day, Ye	ry 28b. Time of Injear)	ury 28c. Injury at Work?  1 Yes 2 X No	28d Describe ho Plastic ba	w injury occurred ag on head an	d helium tanks
ivision or Attence of Attence death Director: I in by the tification	Pending Investigation Fnd 11/22/28e. Place of Inj		factory, office building, etc.	attached 28f. Location (Str	reet and Number or Ru	ural Route Number, City
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification:	3 X Suicide 6 Could not be determined (Specify) Wood	xds		or Town, Sta 11200 Bela	<sup>ite)</sup> air Rd Nottin	gham, MD
0 5	1 29a Certitier			d due to the cause(	(s) and manner as stat	ed.
To the H within 24 To the Fi completel	and manner stated.  29b. Signature and title of certifier	ination and/or investigate	29c. License number		29d. Date signed (Mo	
	Unamio. Mr. Uhill		O.C.M.E.		November 23, 2	
	30. Name and address of person who completed cause of de					
10	Margarita Korell MD. Assistant Medical  31. Date filed (Month, Day, Year)  32. Resistrar		nn Street, Baltimore, MD	21201		<del></del>
State Registra	NI 11 0 0 2007 1 1%	rs Signature	este			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) N Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 12:30 PM NOVEMBER 24, 2007 CHARLES WILLIAM HEAPS SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1002 Southern Drive Bel Air Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Director 212-26-9000 May 11, 1928 Maryland Usual Residence of Decedent **ehow** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 le marked other than "naturel", or Items 23a or 28a-f ehov treumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1002 Southern Drive 21014 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1♥JYes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 permit. Peges 1 and 2 should be filed within Deportment of Health and Mental Hygiane. Important: If Item 27 is marked other than "any Injury or other treumatic event, the Munorial place. Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Broker Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Augustus Heaps Ruby Hill Lewis ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 Southern Drive, Bel Air, Maryland 21014 Ruth Heaps / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burjal / 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Remeval from State Hillton Service Corp 11-26-07 Towson, Maryland 21. Signature of Funeral McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. P. 11. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatio Bladdel Cancel **Physician** ne year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed ettending physicien and for use es the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icete has been sig , page 2 should b 3 robably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificete 1 Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death |Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA this After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ö Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 261 11 07 30. Name an oddress of person who completed cause of death (Item 23a) (Type, Print) 602 S. Atwood Rd., Bel Air, MD 21014 Ashkan Bahrani, 31. Date filed (Month, Day, Year) 32. Asistrar's Signature State 28 freele Registrar

DHMH 17 Rev 1/2001

Division of Vital Records,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ореп нап		I- For State	e of Maryland / L	-	nt of Hea te of Dea			g. No. 201	
Physicia	an/	1. Decedent's Name (First, Middle,Li	ast)				2. Date of Death	201	3. Time of Death 0 /
Medical Exami		Robert S. Hall  4a. Facility Name (if not institution, g	ive street and number)		4b. City,	Town, or Location of	Month November	25, 2007 4c. County of Deati	
		Edgewood Road at Rout				ewood		Harford	
Funeral Director			Sex 7. Age (In	n yrs. last birth	day) If Und Mont	der 1 Year If Under ths Days Hours	Min. 02/08/1	h(MM/DD/YYYY) 9. Bit Foreign	
nd show any ce.	١	10a. State FL. 10b. County Brow	gard 100	c. City, Town o	T) -	erfield E	leach		10d. Inside City Limits   ★ Yes 2 No
ith the Maryland 23a or 28a-f show	Director	10e. Street and Number 17 C	Capitol Court	8B		334 31844	42	ng. Citizen of What Cou United Stat	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shummatic event, the Medical Examiner must be notified at once	Funeral	11 Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorce	12. Was Decedent Events Armed Forces?  1 X Yes 2  If Yes, Give Year WWI	No_	If Yes, spec	dent of Hispanic Orig cify Cuban, Mexican, 2X No specify:	in? ( Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer White, etc. Specify: Whi	te
iours af iatural	d by	15. Decedent's Education (Specify	or Dates:	eted) 16a. D	ecedent's Usua	al Occupation (Give k		16b. Kind of Business	
5-0036 led within 72 hours a Hygiene. other than "natura" the Medical Examin	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+) <b>4</b>			gineer	use retired)	Engineeri	_ng
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Con	17. Father's Name (First, Middle, La Robert S. Hall,	,				s Name (First, Middle, Moothy Hill	Maiden Surname)	
MD 21 td 2 should alth and Me m 27 is ma aumatic ev	٩	19a. Informant's Name/Relationship Michael Hall, So		114	3 Rt.28	Bypass,	ber or Rural Route Num Derry, NH (	03038	
Baltimore, MD 2121 pernit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition  1 X Burial 2 Cremation 3  4 Donation 5 Other Spector	Removal from State	cremato	Disposition (Na ry or other place rood Cen		Date 12/01/2007	20c. Location - City o	
Balti permit. Departu Import injury		21 Si nature of Funeral Service Lice		113			Conte Fund North And		1845
Physician 'Medical		23a. Part I. Enter ine disease, or confailure. List only one cause on	mplications that caused the each line.				· ·	•	Approximate Interval Between Onset and Death
xaminer		or condition resulting in death)	a. Multiple Injuries  Due to (or as a conseque	ence of):					
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury may initiated	Due to (or as a consequ						
ransit - transit	Examin	events resulting in death) Last	Due to (or as a consequent)	ence of):					
be execute iician and urial - trar	Medical	UNPENDED	x AMENDED 10a-	f per	inf g87	75 1-2-08	vt		
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	23c. If yes, outcome of Live birth 4 Pregnant at tim 9 Unknown	2	Fetal deat		pregnancy	23d. Date of delive Month	ry Day Year
O, Bo at the de d by the trached f	/ Phy	Part II. Other significant condition		ut not resulting	in the underlying	ng cause given in Pa	rt I. 23e. Did to	bacco use contribute to	the cause of death?
S, P.C puires that en signed I	ed by								bably 4 Unknown
Records, The law requir	Completed						24a. Was a autop perfor	sy prior to med? death?	completion of cause of  es 2 No
ital Recician: The scertificate rector, page	å	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 500	tpatient 3	26.Place of Death		Residence 6 V Other	ar Saasa
ion of Vital Rec tending Physician: The eath. ior: After this certificate the funeral director, page	<u>ا</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. T	ime of Injury	28c. Injury at Work	? 28d. Describe t	now injury occurred	er. Scene
Sion Attendii death. ector: A	catio	1 Natural 5 Pending 2 Accident Investig	ation			1 Yes 2 🗸	No	struck by auto	tural Route Number, City
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could n 4 Homicide determin	ot be		m, street, racto	ry, office building, et		state) ead at Route 24, Edg	
o the Ho ithin 24 I o the Fu mpletely	Medical	Chook only	ician: To the best of my ki ner: On the basis of examin and manner stated.	-					
	Me	29b. Signature and title of certifier	and/liamer stated.		2	9c. License number O.C.M.E.		29d. Date signed (M November 26, 2	
OCME		30. Name and address of person who Mary G. Ripple MD. D	o completed cause of deat	,	111 Peni	n Street, Baltim	pre. MD 21201		
	C. LC	31. Date filed (Month, Day, Year)	32 spistrar's		p - o -				
Regist		NOV 2 8 2	007	13 1	CINAL P				
- 11VIII 17 NEV 1/2	001			UKI	GINAL				

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2 4 2007 Month 4.151 M **Physician** Vincent Movember 4b. City, Town, or Location of Death
Columbia /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Howard Howard County General Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) February 20, 1917 7. Age (In yrs. last birthday) 90 yrs. Birthplace (State or Foreign Country)
 New York 5. Social Security Number **Funeral** M 2 F 128-03-1257 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County Bethesda 1 ☐ Yes 2 X No Maryland Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20816 U.S.A. 6511 Broad St. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Restaurant / Busines Owner Resauranteur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benedetta Palladino Vincent Iorio ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 5497 Waterloo Rd. Ellicott City, Maryland 21043 19a. Informant's Name/Relationship (Type. Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Douglas Iorio Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 11/30/07 , Maryland St. Gabriel's Catholic Cemetery 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Licens hille MC0531 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. inmediate Cause (Final disease or condition resulting in death) B. laleval Physician /Medical Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 □ Yes 2 □ № 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L ECERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 0.3064129b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 anne November 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back Rova Neck Road Baltinone Mayland 2/22/ 201-109 Subapalli Ramesh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 8 2007 Registrar

State Registrar DHMH 17 Rev 1/2001 Hosain

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland / Dep	eartment of Health an ertificate of Death		giene 007	37881					
П	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	eath Day Year	3. Time of Death					
	/Medic	al	Eileen Esta Julian  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D	11-24-	4c. County of Dea	1:40 A M					
	Examin Funeral Director	er	24 Hillman Court  5. Social Security Number  218-36-2476  6. Sex 1 □ M 2 ☒ F  69 Yrs.	Aberdeen		Harford						
	and w		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or I	ocation			10d. Inside City Limits					
	Maryi	tor	Maryland Harford Aberde	en			1 ☐ Yes 2 X No					
	or 28	Funeral Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?					
	leath v	erai	24 Hillman Court  11. Marital Status 12. Was Decedent Ever in U.S. 13	21001 Was Decedent of Hispanic Origin	? (Specify Yes or No	U.S.A. 14. Race - Ame	erican Indian,					
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Healith and Mental Hygene. If Healith and Mental Hygene. Other traumatic event, tra Madical Examinar must be notified at	by	1 ☐ Never Married 2 ☑ Married I ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P  1 ☐ Yes 2 ▼ No Specify:	uerto Rican, etc.)	Black, Whit	e, etc.					
ָה ה	n 72 h	ietec	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of DO NOT use retired)	working	16b. Kind of Business.	/Industry					
717	d withi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	maker		Own Home						
2	be file	Be	17. Father's Name ( <i>First, Middle, Last)</i> Walter L. McJilton		Name (First, Middle	,						
3	should ind Men marke umatic	ပ္		ling Address (Street and Number o	L. Meyers		Zip Code)					
, Ma	and 2 :		Marlin Julian, Jr. (Husband) 24 H	illman Ct Aberd	leen, MD 2							
palilliore	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other ance.			nosition (Name of ematory or other place) Memorial Gar. 11	Date -27-2007	Bel Air, Ma						
Dall	permit. Depart Import any inj			22. Name and Address of Facility  Inc. 610 W. MacP			ne of Bel Air 21014					
	Physician /Medical			nter the mode of dying, such as car	· · · · · · · · · · · · · · · · · · ·		Approximate Interval Between Onset and Death					
	ificate be executed XX gphysician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):									
.O. DOX	To the Hospital or Attanding Physician: The law requires that the death centif within 24 hours elter death. within 24 hours elter death. To the Funeriel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deteched for use as	Completed by Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	iivery Day Year					
cords, r	quires that n signed b uld be dete	ed by Pt	Part II. Other significant conditions contributing to death but not resulting in the			robacco use contribute to						
פנים	The law re ate has bee page 2 sho	Complet	Diaheles Hyperlipie		24a. Was auto perfo	ormed? death?	utopsy findings available completion of cause of					
<u> </u>	ician: certific rector,	Be	25. Was case referred to medical examiner?	0.1	Death (Check only							
VISIOII OI	nding Physath. r: After this e funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Accident Splitter 1 Inpatient 2 ER/Outpatient #IL 3 DOA 4 INUISI	28d. Describe	dence 6 Other (Spe how injury occurred	cify)						
N N	tal or Atte 's efter dea ei Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location ( City or To	Street and Number or Ri wn, State)	ural Route Number,					
	he Hospil in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dead one)  1 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death o	occurred at the time,	date and place, and due	to the cause(s)					
	To t Com	Σ	29b. Signature and title of certifier	29c. License number	7	29d. Date signed (Mont	h, Day, Year)					
			30. Name and address of person who completed cause of death (Item 23a) (Type	p, Print)		7400	*/ XOUT					
	N		JOSEPH ANGEZO, # 205	602 S ATWOS	D Rd.	BEL AFR	MD 21014					
	Sta Registr		29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type To:SEPH An 4 EZ o # 255  31. Date filed (Month, Day, Year)  32. Registrar's Signature	carles								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 25 **Physician** 2007 10:00PM Jeffree Todd Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Howard Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

July 29,1964 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** New York 1 13 M 2 □ F 219-88-9533 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 3 ☐ No Elkridge Howard Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or i U.S.A. 6300 Marshalee Drive 21075 Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other them? any injury or other traumant. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: Specify: ģ Year or Dates: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sr. Systems Analyst Fannie Mae Foundation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Faith Fulton Earl Jones ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 6300 Marshalee Dr. Elkridge, MD 21075 Petra Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. Dec. 3, 2007 Owings Mills, MD 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> Witzke Funeral Homes, Inc 5555 Twin Knolls Road Co M01050 Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician - ARDIAC /Medical Due to (or as a consequence of): **Examiner** H164 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine M12812 To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 023081 -26-07 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9650 Santiago Road Dr. Robert S. Goodwin Columbia, MD 21045 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Registrar

2007

NOV 28

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year JoAnn Pauline Jordan 23, 2007 8:45 /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 F Vrs Director 219-16-8820 Feb. 27, 1925 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be a 3707 A Funeral Penny Lane 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Job Placement State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Peter Trott ပ Anna N. Stroehla 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joel E. Jordan Sr. / Son 1524 Murray Place, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4 □ Donation 5 □ Other (Specify) Oaklawn Cemetery 11-26-07 Baltimore, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. Lissell 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Myocandial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 20 No Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has been si rector, page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours of To the Funeral D exirifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00036487

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** DELORISE FLORINE NOVEMBER 22,2007 6:56 pM KAISS /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JUNE 3,1925 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 💢 F Min. 218-36-9038 82 Yrs. MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 √Yes 2 No MD. N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3426 DILLON STREET 21224 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ites 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ Specify: 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 WILLIAM TUCKER CATHERINE KLATTENBURGER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUISE G. NELSON/ DAUGHTER 3426 DILLON STREET, BALTIMORE, MD. 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of H Important: If Ite any Injury or of 1 Surial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) CEDAR HILL CEMETERY 11/26/07 BALTIMORE, MARYLAND 21. Signature of Fundamental Editions of Fundamental Editions of Fundamental Edition (1997) and Fundamental Edition (1997) a 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Po not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence A bue Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of) physician s the burial Division or Vital Records, P.O. Box 68760 Physician/Medical attending p for use as 1 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has b rector, page 2 sl 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death Check only one) 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Leath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after oc... ral Director: At 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide filled in !

DHMH 17 Rev 1/2001

State

Registrar

within 24 hours a

To the Funeral I

completely filled

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SIMON SCALIA, M.D.

NOV 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2801

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

HUDSON STREET, BALTIMORE, MARYLAND 21224

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For 1 _ State	State of Marylan		-		Mental Hyg	giene	27006
	-		Registrar  1. Decedent's Name (First, Middle, Last)	)		Certificate of	Death	2. Date of Dea	Reg. No LUU/	37886 3. Time of Death
	Physicia //Medic		David Ki	ones				Month	Day Year	-450
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Deat		4c. County of Dea	th
ساست			Northwest f 5. Social Security Number 6. Se	το ερίται x 7. Age (In yrs.	last hirth	day) If Under 1 Year	Sal(Sto	. 8 Date of Birth	Baltin	thplace (State or Foreign
Ŀ	Funeral Director		218-05-3189	M 2□ F 91		Months Days	Hours Min.			MD
	/land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town	or Location				10d. Inside City Limits
	e Mary 3a-f sh tiffed	Director	MD BALTIMORE	E F	RANDA	ALLSTOWN				1 ☐ Yes 2 No
	with th a or 2	Dire	10e. Street and Number 3801 SCHNAPER DR	VE #204		10f. Zip Code	22		10g. Citizen of What C	ountry?
	ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S.	211 13. Was Decedent of H If Yes, specify Cub		Specify Yes or No-	U.S.A. 14. Race - Am	
020	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 5 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 MYes 2 □ No WW If Yes, Give Year or Dates: ARMY	II	If Yes, specify Cub	an, Mexican, Puer Specify:	rto Rican, etc.)		te, etc. HITE
ה ה	72 ho "natur dical	eted	15. Decedent's Edu (Specify only highest grad	cation e <i>completed</i> )	(	ecedent's Usual Occup Give kind of work done	during most of wo	orking	16b. Kind of Business	
7	within iene. than the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retire  LLECTOR	a)		BALTIMORE COLLECTION	
ב	ould be filed with Mental Hygiene. arked other than atic event, the N	Be C	17. Father's Name (First, Middle, Last)		-			me (First, Middle,	Maiden Surname)	
N N	should b ind Ment marked umatic e	2	SAMUEL			(IPNES	SADIE			LEVINE
Z	id 2 sho Ith and 27 is ma trauma		19a. Informant's Name/Relationship (7) RONA GUSLER / DAU	ipe. Print) IGHTER		Mailing Address (Street				
, E	s 1 and 2 of Health Item 27 I		20a. Method of Disposition	20b. F	lace of [	B6 WOLF HIL Disposition (Name of	>	Date	EAD, MD.21( 20c. Location - City of	Town, State
altillo	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		1 X Bunal 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)			TON" CHTZUK CONG.		25/2007	BALTIMORE,	MD
מ	permit Depart Import any in once.		21 Signature of Funeral Service Licen	ee		22. Name and Addre			SON & BROS	
r	3 -31		23a. Part1. Enter the disease, or comp shock, or heart fallure. List only o	ications that caused the deat	h. Do no				PIKESVILLE,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to for as a conseq	uence of	- 1	2			
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0	death e atter d for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of de Month	elivery Day Year
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2	law re las bee	Completed	Atrial File	milation				24a. Was		utopsy findings available completion of cause of
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VILAI	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outs	patient 3 DOA Oth	oor:	eath <i>(Check only o</i>	ne) dence 6 □Other(Sp	ecifu)
	ng Phy fter thi	-	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Ti		rv at	7	now injury occurred	sony)
JIVISIOU	Attending r death. ector: After by the funer	catic	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At he	omo fari		]Yes 2 □ No	20f Location /6	Street and Number or F	Pumi Pouto Alumbar
2	al or A s after il Direct ed in by	Certification:	4 ☐ Homicide determined	building, etc. (Special	(y)	n, street, lactory, office		City or Tox		idiai nodie Numbei,
	To the Hospital or Attending Physician: Within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)	sician: To the best of my kno Iner: On the basis of examina and manner stated.	wledge, ation and	death occurred at the ti /or investigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mor	
•				MO		DO	0661	71	November	W 21 205
	3		30. Name and address of person who c	_	n 23a) (T <b>-{ O (</b>	ype, Print)	+ Rose	1 P	lalic Lev. ) A	W 21 205
	Sta		31. Date filed (Month, ₽ay, Year	32. Redietrar's Signa		00	· 1-000	y ranc	MALL ZILLEY	(1/1)

Registrar



DHMH 17 Rev 1/2001

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			1 - State Registrar	,	Ĉe	ertificate of	Death	R	eg. No.	0 ,	0,00	,
Ä	Physici	an	1. Decedent's Name (First, Middle, Last)	Inna				2. Date of Deat Month	Day	Year	3. Time of Dea	ath
	/Medic		Robert Walter	Lange				Novembe:		2007	10:00p	М
	Examin	er	4a. Facility Name (If not institution, give st Transitions Health	n Care		Sykesvi		·	Carro.	11		
	Funeral Director		212 20 30 11 11	7. Age (In yrs. 85	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 5	rear)	9. Birth	place (State or Fo	reign
	land		Usual Residence of Decedent  10a. State 10b. County		ty, Town or L						10d. Inside City Li	imits
	Many	tor	MD Howard	F	Ellicot	tt City					1 □ Yes 2)X	No
	deeth with the Maryland ims 23e or 28a-f ehow r.must be notified at	Funeral Director	10e. Street and Number 3498 Chatham Road			10f. Zip Code 21043		1	0g. Citizen of USA	What Cou	ntry?	
	ems ;	Iner	11. Marital Status	Was Decedent Ever in L Armed Forces?	J.S. 13	. Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri	ican Indian, etc.	
0000	ral', or it	by	1 Never Married 2 Married 3 Widowed 4 Divorced	ty⊡Yes 2 □ No WW I¥Yes, Give Year or Dates:	/II	1 ☐ Yes 2 ☐XNo	Specify:		Specil	√ whi	te	
ה ה	"natu	Completed	15. Decedent's Educ (Specify only highest grade		(Giv	edeni's Usual Occup e kind of work done DO NOT use retire	during most of work	ring	16b. Kind of B		•	
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land 4	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. The proportant: If Item 27 is marked other than "natural", or Items 23e or 28e-1 ehow eny injury or other treumatic event, the Medical Examinar must be nutified at once.	To Be C	17. Father's Name (First, Middle, Last)  Carl Lange	ne (First, Middle, Maiden Sumame) .rk								
, mary	and 2 sho laith and h		19a. Informant's Name/Relationship (Type Scott Lange (son)	e, Print)		ling Address (Street 9 Hucklebe						
more	Peges 1 and of He		20a. Method of Disposition  1 XBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	cemetery, cri	position (Name of ematory or other place of Memorial	ce)		ykesvi	-		
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ı			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	th. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Betwee	en
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	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):							
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0.00	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within £4 hours eiter death. To the Funerel Director: After this certificate hes been signed by the eitending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fet: 4 Pregnant at time of o 9 Unknown	al death 3	□Ectopic pregnanc □ Other (specify) _	<b>y</b>	n		ate of deliv	Day Year	r
ds, F.	signed by	þ	Part II. Other significant conditions conf	ributing to death but not re	sulting in the	underlying cause giv	ven in Part I.		bacco use cor	tribute to	the cause of death	
cords	w requ	iete						24a. Was a	ın 24b.	Were aut	opsy findings ava	ulabie
D L	The la	Completed						autops perfor	SV	prior to α death? 1 ☐ Yes	ompletion of caus	e of
<u> </u>	sten: artifice ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat			1		
5	hysic this ce al dire	2	1 ☐ Yes 2 反 No		ER/Outpation		464 Nursing Ho	ome 5 Resid			ify)	
	ding F Ih. After funera	tion	27. Manner of Death  Natural 5 Pending  Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ryat rk? Yes 2 □ No	28d. Describe h	ow injury occu	rred		
DIVISION	of or Attender dear of the Color dear of the Col	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, s ify)	street, factory, office		28f. Location (S City or Town		ber or Rui	ral Route Number,	:
	Mospite 24 hours Funerel etely filled	edical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, dea ation and/or	ath occurred at the tri investigation, in my c	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and m late and place	anner as , and due	stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens		1	29d. Date sign	ed (Month	, Day, Year)	
			1 1 1			194	3725		11/2	710	7	
	P		30. Name and address of person who con	- 10 0	-	e, Print)	1 We	i fmin	ر. صله	Mr	2111	7
	Sta	te.	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature 1	8 ,2000	7 102	J CF (IP)	110		2115	1
	Registr		NOV 2 8 200		5 6	asses						

Registrar

32. Registrar's Signature

2007

10c. City, Town or Location

Timonium

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Specify

Certificate of Death

10b. County

9318 Bel Air Road

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12th

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

29b. Signature and tiple of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

1 ☐ Yes 2 📉 No

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

Maryland | Baltimore County

15. Decedent's Education (Specify only highest grade completed)

Francis Joseph Lavin, Sr.

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Foneral Sovice Ligensee

Martin D. Lawson

10a. State

10e. Street and Number

11. Marital Status

ns 23a or 28a-f show must be notified at

if item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must b

Physician

Examiner

ed by the attending physician detached for use as the buria

Physician/Medical

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Completed

Be

Certification: To

IF FEMALE:

/Medical

Directo

Funeral

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Completed

Be ဥ

2. Date of Death 3. Time of Death November 22, 2007 12:30P M 4b. City, Town, or Location of Death

4c. County of Death

Baltimore County

 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Sept 20, 1960 Maryland

10d. Inside City Limits 1 ☐ Yes 2X No

Nottingham 10g. Citizen of What Country?

21236 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc.

Margaret Patricia Murray

Specify: White 16b. Kind of Business/Industry

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor Home Improvement

18. Mother's Name (First, Middle, Maiden Surname)

19a. Informant's Name/Relationship (Type. Print) (Parents) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Mr. & Mrs. Francis J. Lavin, Sr. 908 Sidehill Drive, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley M. Grdns 12/1/2007 Timonium, Maryland

22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212
Approximation acceptable areast

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

LIVER DISEASE

Due to (or as a consequence of)

1 ☐ Yes 21 No

Due to (or as a consequence of)

Due to (or as a consequence of)

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

College (1-4or 5+)

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 5 ☐ Other (specify)

3 ☐ Ectopic pregnancy

23d. Date of delivery Month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

and manner stated.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

autopsy performed' 2X No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

TEL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number ひんろつ21~ 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year) State NOV 28

32. Registrar's Signature Gosner

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28h. Time of

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 NOVEMBER 22,

or Vital Records, P.O. Box 68760 Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 2.29d per doc 874 12-26-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2007 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ARTHUR LEVINE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death Examiner UNIN 17hhi Social Security Number 6. Sex 1 M 2 □ F Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/30/1932 9. Birthplace (State or Foreign Sirthpica Country) **Funeral** Months Days 132-24-0532 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 X No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 3421 GARRISON FARMS ROAD 21208 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or Ite Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 EXECUTIVE SHOE MANUFACTURING Baltimore, Maryland ? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL LEVINE ဂ္ FVA KADE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUDREY LEVINE / WIFE 3421 GARRISON FARMS ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 XBurial 2 □ Cremation 3 □ Removal from State MOUNT ARARAT 4 Donation 5 Dother (Specify) 11/26/2007 FARMINGDALE, NY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. Mast 8900 REISTERSTOWN ROAD - PIKESVILLE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseguen Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE asn 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2□ No 1☐ Yes 2 □ № 1 TYes fur eral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient Certification: To 2 ER/Outpatient 3 DOA Af er this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending (Month, Day Year) 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No ours after death.
neral Director: / 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) tle of certifier 29c. License number 29b. Signature and 29d. Date signed 23 onth, Day, Year) Bagistrar's Signature 31. Date filed (Month, Day, Year) -State Registrar

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thony McNeil		State of Maryland / Department of Health and Mental Hygierie  1-For State  Certificate of Death  Reg. No.	0007 0700
Physicia	an/	Registrar  1. Dacegon'ts Name (First, Middle, Last)  2. Date of Death Month Day	Year 0944 hrs
edical Exami			. County of Death
		409 North Luzerne Avenue  Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/II)	DD/YYYY) 9. Birthplace (State or Foreign
Funeral Director		219-50-5033 1XM 2 F 59 Yrs. Months Days Hours Min. 08 15 /	948 Country) MD
any	}	Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location	10d. Inside City Limits
Maryland 28a-f show d at once.	ğ	MD Baltimore	1 XYes 2 No zen of What Country?
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygeria. However, is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10g. Street and Number 409 Luzerne Avenue 21224	USA
eath with items 2	ınera	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	14. Race - American Indian, Black, White, etc.
after d	by Ft	3 Widowed 4 Divorced or Datas:	Specify: <b>black</b> (ind of Business/Industry
72 hours n "natu al Exan	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4 or 5+)	0 5
5-0036 Led within 7 Hygiene. to ther than	dmo	12th Examiner D	ocial Security
21215-0036 hould be filed within 72 and Mental Hygiene. is marked other than "	Be C	Lee C. Mc Neil Christine C	raven
MD 21215-003 d 2 should be filed withi tth and Mental Hygiene. n 27 is marked other th	٩	19a Informant's Name/Relationship (Type, Print)  (Mother) 2117 W. Letington St., Ball	Ho, MD 21223
Baltimore, MD 2 pernit. Pages I and 2 shoul Oppartment of Health and N Important: If them 27 is in injury or other traumatic		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery)  20c.  1 X Burial 2 Cremation 3 Removal from State	Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hec Important: If ite injury or other tr		21. Signature of Fligeral Service Licensee 22. Not and Add ass of Fability See 14	eral Services
ம் ഉമ്മദ Physician		23a. Pert I. Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she	ock, or heart Approximate Interval
Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b	
	niner	if any, leading to immediate cause. Enter Underlying Cause	
ted I msit	Examiner	(Diseasa or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
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3760, ificate be ex g physician s the burial			3d. Date of delivery  Month Day Year
Box 6876 ne death certificat the attending phined for use as the	Physician/	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  9 Unknown	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi			o use contribute to the cause of death?
rds, P.O.  v requires that the s been signed by the	ed by	1   Yes 2	No 3 Probably 4 ✔ Unknown  24b. Were autopsy findings available
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed	autopsy performed?	prior to completion of cause of death?
tal Rec cian: The l certificate l ector, page		25. Was case referred to medical 25. Flace of Death (Check thirty offe)	No 1 Yes 2 No
Vital   hysician: this certifi	o Be	O 1 Yes 2 No 1 inpatient 2 ENOutpatient 3 DOA 4 interior of its contraction	lence 6 Other: Scene
ion of Vi tending Physi eath. or: After this	on:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how in 1 Yes 2 No	jury occurred
Division tal or Attendi rs after death. al Director:  led in by the fu	ficati	2 Accident Investigation Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street or Town, State)	and Number or Rural Route Number, City
Divisi spital or Att hours after d neral Direct filled in by	Certification:	determined (Specify)  4 Homicide  29a. Certifier A Certifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) a	
Division  To the Hospital or Attentwithin 24 hours after death To the Functal Director: completely filled in by the	Medical	29a. Certifier (Check only one)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) a (Check only one)  29a. Certifier 1  Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and p and manner stated.	lace, and due to the cause(s)
To Mi	ĕ		Date signed (Month, Day, Year)
7		30. Name and address of person who completed cause of death (Item 23a)	VGIIIDGI 20, 2001
1		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
S Regis	tate		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 23aPtII, 25 per me 28/3, 11/20/07dhb Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Colore **Physician** James /Medical 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Homes If Under 1 Year Months Days place (State or Foreign If Under 24 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Min. 1 XM 2 ☐ F 86 Yrs. 10 21 SC 01 Director 579-14-0340 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ns 23a or 28a-f show must be notified at 1 Yes 2 No Director Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 21217 U.S.A. 301 McMechen Street Apt # 1116 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? "natural", or item edical Examiner r Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 🎾 No Specify: Black Saltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natury injury or other traumatic event". traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Office Supervisor 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 9 <u>Fannie Davis</u> James Andrew Meek Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 70th Place, Hyattsville, Md 20784
ition (Name of Date 20c. Location - City or Town, State Karen Meek-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10/29/07 Baltimore Co, Md Woodlawn 1. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West my 21215 4300 Wabash Ave, Baltimore, Md 23a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tortic Imp ediate Cause (Final difference or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): PROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncerying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transi CERTIFIC Due to (or as a consequence of). Box 68760, be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 I Inknown 9 ☐ Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Completed 24b. Were autopsy findings available prior to completion of cause of Hepatocellular Disease 24a. Was an autopsy performed death? 2 **20**0 Was case referred to medical examiner? 1 Yes 2 2000 or Vital 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2000 1 patient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural
2 Accident Division or Attending 5 ☐ Pending investigation Within 24 hours after com.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier edial Center 301 F. Paul Place 31. Date filed (Month, Day, State 0 Registrar

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Registrar

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		-	State of Maryland / Department of State Amend #23a Per PHY 0874 12/18/07 JF Certificate of Certificate of State Registrar	Health and Menta		e	37891			
	Physicia /Medic Examino Funeral Director	an	Decedent's Name (First, Middle, Last)	0.6	ay Year	3. Time of Death				
Fire			Carole Joan McMahon  4a. Facility Name (If not institution, give street and number)  4b. City, Town,	or Location of Death		2007 c. County of Death	2:25P <sup>™</sup>			
		GI.	Stella Maris Hospice Timonium			Baltimore				
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Days	s Hours Min. (M	te of Birth onth, Day, Yea	r) Cou				
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	th the or 28a e noti	Jirec	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Cou				
	ath wi	ral	1989 Blair Ct. 210			U.S.A				
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 1 Yes 2 No If Yes, Sive Year or Dates:	f Hispanic Origin? (Specify Yoldan, Mexican, Puerto Rican, OSpecify:	es or No- etc.)	14. Race - Ameri Black, White Specify: Wh	etc.			
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121			5+ Teacher  17. Father's Name (First, Middle, Last)	18. Mother's Name (First		blic Scl	1001			
Maryland			Alphonse McMahon	Margaret						
Mar				et and Number or Rural Rout c Court Bel	•		_ '			
			20a. Method of Disposition (Name of	Date		Location - City or T				
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Baltimore,		, 1		tives 8717			s Dr. MD			
	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line.		iratory arrest,		Approximate Interval Between Onset and Death			
			Immediate Cause (Final disease or condition resulting in death)  a. DEMENTIA Cerebrovascular.  Due to (or as a consequence of):	Accident						
		niner	Sequentially list conditions, if any, leading to immediate cause. Experience of the characteristics of the constant of the characteristics of the characteristic							
,09		Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C							
9289		dical	d							
.O. Box 6		Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnant 4 □ Pregnant at time of death 5 □ Other (specify)			23d. Date of deli	very Day Year			
Δ.		by Pf	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I. 2	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown					
ord										
or Vital Records,		Completed			4a. Was an autopsy performed? ☐ Yes 2 <b>1</b> 21	prior to c death?	opsy findings available ompletion of cause of			
/ita		Be (	25. Was case referred to medical examiner?	26. Place of Death (Che						
or	Phy rthis ral di	. To	To The Late of the	Other: 4 Nursing Home 5	Residence		ify) HOSPICE			
ion	ttending P death. stor; After	tion	1 N Natural 5 Pending (Month, Day Year) Injury W	ujury at 28d. D Vork? □ Yes 2 □ No		,,				
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Street ity or Town, Sta	and Number or Ru ate)	ral Route Number,			
		Medical (	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		Me	Zob. Olginated and angles of the	onse number 0 43721		Date signed (Month				
_	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093							
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature		21073					
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Registrar

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de		-3	Registrar  1. Decedent's Name (First, Middle, Last)							. Date of De				
>	Physici		MARY AGNES QUINN MALLONEE				Month Novembe				er 25	Year 2007		
	/Medic Examir		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death					c. County of Death		
The second			Holy Cross Hospital				Silver Spring				Mon		tgomery	
	Funeral				(In yrs. k	ast birthday)	If Under 1 Year Months Days	If Under Hours	Min.	Date of Birl (Month, Da	y, Year)	C	rthplace (State or Foreign ountry)	
	Director			<sup>1□ M</sup> XX F 10	01	Yrs.			I I	April	26,	190 <b>6 1</b>	Maryland	
	and and	Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County	1	10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Mary -f sh fied a		Maryland Prince	George's	Tiá	aurel							1□Yes 2□No	
	h the r 28a		10e. Street and Number	000190 0			10f. Zip Code				10g. Citiz	en of What C		
	r death wit lems 23a c er must be		329 Laurel Avenue	9			20707	7			U.S	3.A.		
			11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Oi an, Mexica	rigin? (Speci	fy Yes or No can, etc.)	- 1	4. Race - Am Black, Whi		
36	s afte		1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced	1 ☐ Yes 2 XXIIIo If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>XX</b> No <i>Specify:</i>					Specify: White			
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yla	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Thomas P. Quinn							Mollman				
Mai			19a. Informant's Name/Relationship Mary Jo Mallonee	(Type. Print) / goddaug	xh+o:		g Address (Street a					, ,	, ,	
Baltimore, Maryland 21215-0036	1 an Healt tem 2		20a. Method of Disposition	/ goddau	20b. PI	ace of Dispo	sition (Name of	i	Dat			ation - City or		
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al‡	oartme		21. Signature of Funeral Service Lice		00.							-	i y i di i d	
ä	Dep Imp any onc		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral Home, P.A.  313 Talbott Avenue Laurel, Maryland 20707											
	Cate be executed /Medical Examiner the burial-transit		23a. Part1. Enter the disease, or con shock, or heart failure. List on	nplications that caused to	he death	. Do not ente	er the mode of dyin	ig, such as	s cardiac or r	espiratory a	rest,		Approximate Interval Between	
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		J.	resulting in death)  Due to (or as a consequence of):											
			Sequentially list conditions, if any, leading to immediate  b. Pneumonia  Due to (or as a consequence of):											
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8760,			d											
9	ntifica ng ph as th		IF FEMALE:	-										
Box	leath certific aftending p		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant Colon Cancer   23c. If yes, outcome pf pregnancy   1 □ Live birth   2 □ Fetal death   3 □ Ectopic pregnancy   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □ □ Unknown   5 □ Other (specify) □									3d. Date of de	delivery Day Year	
o.	The law requires that the death certificate has been signed by the aftending page 2 should be detached for use as	/sici								- North Day Year				
σ.	uires that the de signed by the a Id be detached f								l.	23e. Did tobacco use contribute to the cause of death?				
Records, P.	uires sign Id be	on: To Be Completed by								1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXInknown				
Ö	w rec		Urinary Tract In	footion						24a. Was	an	24b. Were a	utopsy findings available	
	The Is te has age 2		Offmary Tract In	rection						autop perfo	rmed?	prior to death?	completion of cause of	
Vital	lan: rtifica ctor, p		25. Was case referred to medical					26. Plac	e of Death (	1□ Yes Check only o	ne)	1 □ Yes	8 2文次0	
Division or V	Physician: The law requir this certificate has been s al director, page 2 should		examiner? 1 ☐ Yes 2 <del>/ X</del> No	Hospital: 1 Typatien	t 2 🗆 E	ER/Outpatien	t 3□ DOA Othe	er: 4□N	ursing Home	5 ☐ Resid	dence 6	□Other (Spe	ecify)	
	Attending Physician: r death. ector: After this certifics by the funeral director, p		27. Manner of Death  1 XX atural 5 ☐ Pending	28a. Date of Injury (Month, Day	ay Year) Injury Work?									
	ttend leath tor: / the f	cati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be	,		M 1 ☐ Yes 2 ☐ No eet, factory, office 2			28f. Location (Street and Number or Rural Route City or Town, State)					
<u>&gt;</u>	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	4 ☐ Homicide determined	28e. Place of injury - At home, farm, stre building, etc. (Specify)				201				turai Houte Number,		
	Hospital 24 hours a Funeral I	Medical Ce	29a. Certifier XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in I		(Check only 2 Medical Exa	miner: On the basis of and manner state	examinati ed.	ion and/or inv	estigation, In my o	pinion, de	ath occurred	at the time,	date and	place, and du	e to the cause(s)	
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	1)	/		29c. License	e number			29d. Date	signed (Mon	th, Day, Year)	
)			Wan K	Segal	1	44	D 52	2261			Nove	ember 2	25, 2007	
1	6		30. Name and address of person who	// 1				1			0.00	210 340		
	200	to.	Alan R. Segal, M. 31. Date filed (Month, Day, Year)					Liver	sprir	ıg, MD	209	910-148	5 4	
	Sta Registr		NOV 2 8 20	32. Registrar	13	A DE	all so							
				AP .		- 3								

DHMH 17 Rev 1/2001

Dorothy Joan Mort	1.	State of Maryland / Department of Health and Mental   Certificate of Death		g. No. 200	7 3789
Physician	-	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month November		3. Time of Death 0120 hrs
Medical Examine		DOROTHY J. MORTON  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dec		16, 2007 4c. County of Deati	
		Laurel Regional Hospital Laurel		Prince George	
Funeral	Ę	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24			thplace (State or Foreign ountry)
Director		103-22-5242	July 1	6, 1930	Canada
any	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
( )	_	MD Prince George's Laurel			1 Yes 2 XXNo
the Maryland as or 28a-f sh		10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	5	9000 Briarcroft Lane, #135 20708		USA	
death with in items 233	era 	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue		14. Race - Amer White, etc.	ican Indian, Black,
ter des	- [	1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 XX No specify:		Specify: Wh:	ite
ours aft	ō'-	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind		16b. Kind of Business	
-0036 I within 72 hoursgiene. her than "natue Medical Exan		Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use	,	Our Savio	or
within giene.		12th Ø Administrative Assis	stant me (First, Middle, N	Lutheran	Church
215- be filed nital Hyg riked oth ent, the	וי	17. Father's Name (First, Middle, Last)  John Brunton  Dora	me (First, Middle, N Dearbor	•	
212 212 Ment be Ment mark		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of			e, Zip Code)
MD d 2 sho th and n 27 is	Ĺ		aurel, MD		
rre, s I am of Heal of Heal	- 1	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City o	r Town, State
Page Page ment crant crant:		4 Donation 5 Other Specify: West Arundel Crem. 11	L/21/2007		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica	F	21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
Physician	1	23a. Prit Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia			Approximate Interval
/Medical	-	ail re. List only one cause on each line.			Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
	_   ;	Sequentially list conditions, b. Complications of congestive heart failure			
led nsit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			
y g ig ig	Xa	events resulting in death) Last Due to (or as a consequence of):			
execut in and il - tra		M. UNPENDED AMENDED. 1 07 NR 075 1/15 (00 FFF			
68760, certificate be executed noting physician and tee as the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ry
687 ertifica ding p	2	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pre	gnancy	Month	Day Year
). Box 687 the death certification by the attending phe deforuse as the Physician/I	Sic	4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
Division of Vital Records, P.O. Box 687 also rattending Physician: The law requires that the death certificrs after death.  al Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the refinentian: To Be Commissed by Physician!		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
P. P. ires that is signed by de	o o		1 Yes	2 No 3 Pro	obably 4 V Unknown
ords A requ	E E		24a. Was autop		utopsy findings available completion of cause of
Records, The law requires ficate has been sig	Ē		perfor	rmed? death? 2 No 1 ✔ \	es 2 No
cian: certific	2 ادء	25. Was case referred to medical examiner?  Hospital: 4   Inspital: 3   EP/Outpatient 3   DOA   Other, Number 1			
F Vil	٩L	1 Yes 2 No Inspired 1 Inpatient 2 ER/Outpatient 3 DOA		Residence 6 Other	er:
on o ding th. : Afte e funer	<u>:</u>  '	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	280. Describe i	low injury occurred	
isio Atter er dear rector by th	ğ	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	Street and Number or F	tural Route Number, City
Division o spital or Attending nours after death. neral Director: Aft filled in by the fune Certification:		3 Suicide 6 Could not be determined (Specify)	or Town, S	tate)	
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	and due to the caus	e(s) and manner as sta	ited.
To the H. within 24 To the Fr completel		2 windows and manner stated.  29b. Signature and title of certifier  29c. License number	ed at the time, date	29d. Date signed (M	
	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	O.C.M.E.		November 16, 2	
	3	30. Name and address of person who completed cause of death (Item 23a)			
Ø		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		
State Registra	_	31. Date filed (Month, Day, Year)  32. By Sistrar's Signature			
DHMH 17 Rev 1/2001	1	ORIGINAL		DOME	-

Months

MEDICAL CENTER

7. Age (In yrs. last birthday)

81

Yrs.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

NOVEMBER

8. Date of Birth (Month, Day, Year)

3-14-1926

Month

MORRIS

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

BALTIMARE

Days

Day

Year

4c. County of Death

10g. Citizen of What Country?

USA

16b. Kind of Business/Industry

Seafarer Union

20c. Location - City or Town, State

Race - American Indian, Black, White, etc.

White

2007

1206 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

HOURS

MONTHS

1 Yes 2X No

New York

n who comple

NOV 2 8 2007

EDWIN OUTEIN 31. Date filed (Month, Day, Year)

Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

BAYVIEW

1√2 M 2□ F

6. Sex

WILLIAM

JOHNS HOPFINS

119-14-1974

5. Social Security Number

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

LVNG CANCE		e en c e			18 MONTHS
Due to (or as a conseq		TICEL OF TH	le way		6 TEARS
yes, outcome of pregna □Live birth 2 □ Feta □ Pregnant at time of c □ Unknown	il death 3 □Ectopi	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
_		ng cause given in Part I.	23e. Did tobacc	co use contribute	to the cause of death?  Probably 4 □Unknown
			24a. Was an autopsy performed	? prior to death?	
		26. Place of D	eath (Check only one)		
al: 1 npatient 2 🗆	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Sp	ecify)
a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
Place of Injury - At h building, etc. (Special	ome, farm, street, fac (y)	ctory, office	28f. Location (Street City or Town, St		Rural Route Number,
To the best of my kn. in the basis of examinating manner stated.	wiedge, death occur ation and/or investiga	red at the time, date and pla- tion, in my opinion, death oc-	curred at the time, date	s(e) and marrier a and place, and du	ue to the cause(s)
		29c. License number	29d.	Date signed (Mor	nth, Day, Year)
7. PH. P.		RES-600	100	VEMBER	22, 2007
ed duse of death (Iter	19 to EAS	TERN AVENU	E BALTIME	DRE, MO	21224
Million L	ORIGINAL	and the same of th			

State Registrar

5x1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08501 State of Maryland / Department of Health and Mental Hygiene David McCullough Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month November 1, 2007 1738 hrs Medical Examiner David McCullough 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** University Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Hours Min Country) Director 03/07/1966 AL 1 X M 2 F Yrs 417-13-6736 41 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No item 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examiner must he notified at once. Montevallo Shelby Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number United States 35115 13784 Highway 17 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Married 1 X Yes 2 White Specify f Yes, Give Yaar 1984 – <u>85</u> Yes 2 X No specify: Widowed 4 XDivorced ğ 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hor Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nainjury or other traumatic event, the Medical Exiting or other traumatic event, the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exiting States of the Medical Exit States of the Medical Exiting States of the Me College (1-4 or 5+) Elementary/Secondary (0-12) Not Self Supporting Dependent 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Linda Cash Leroy McCullough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13784 Highway 17, Montevallo, AL 35115 Linda Lawley, Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 XCremation 3 Removal from State 11/20/2007 Baltimore, Maryland Bayview Crematory Donation 5 Other Specify 22. Name and Address of Facility Harman Funeral Service, Import injury 21. Signature of Funeral Strville Licensee 7221 Grayburn Drive, Glen Burnie, MD 21061 art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line. Death /Medical Heroin and alcohol intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last ABCOLUS, 1.... The law requires that the death certificate be executed Physician/Medical attending physician for use as the burial -X UNPENDED 4\frac{4\frac{1}{2}}{2}\frac{1}{2 Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Š Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy . death? performed? 2 No ✓ Yes 2 1 🗸 Yes certificate 26 Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes No ဥ 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: within 24 hours after acare.

To the Funeral Director: A 1 Natural 1 Yes 2 X No unk Pending Fnd 11/01/2007 Fnd 5:20 pm 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide or Town, State) determined 2100 Washington Blvd. Baltimore, MD (Specify) other-scene Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

D

State Registrar Zabiullah Ali, M.D. A

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

ire Assik

**ORIGINAL** 

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

November 2, 2007

			For	Glate of Ivial		epartment of F		nemai myg	jiene		
			1 - State Registrar			Certificate of	Death	-	Reg. No	2007	137900
	Physicia	an	Decedent's Name (First, Middle, La     MICHELLE MARIE					2. Date of Dea	Da	y Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		<del>-</del>	4h City Town o	r Location of Death	NOVEMBE		. County of Death	5:00 P <sup>M</sup>
	Examin	er	SUMMIT HEALTH PAR			CATONSVI				ALTIMORE	
	Funeral	0			In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birti	h	9. Birth	place (State or Foreign
	Director		216-70-4791	¹□м 2ष्र्रF 3	6	Yrs. Months Days	Hours Min.	NOV . 1	i, T	971 MAR	LAND
pu	>		Usual Residence of Decedent  10a. State 10b. County	1	l0c. Citv. Towr	or Location					10d. Inside City Limits
aryla	shov ed at	j	MARYLAND ANNE ARU		GLEN BU						1 □Yes 2 No
the M	28a-f notiffie	ecto	10e. Street and Number			10f. Zip Code			10a. Cit	tizen of What Co	intry?
with	a or	Ö	7827 BALTOANNAP	BL.VD		21060				TED STAT	
death	ms 2:	<b>Funeral Director</b>	11. Marital Status		er in U.S.	13. Was Decedent of H	lispanic Origin? (Sp			14. Race - Amer	ican Indian,
after	or ite		1 X Never Married 2 Married	12. Was Decedent Even Armed Forces?  1 Yes 2 No If Yes, Give		1 ☐ Yes 2X No	an, mexican, Puero Specify:	Hican, etc.)		Black, White	, etc.
S no	and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medkel Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		ļ					WHITE
72 h	"natı	Completed	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of world do	king	16b. K	ind of Business/I	ndustry
withir 6	than	щ	Elementary/Secondary (0-12)	College (1-4or 5+)	DI	SABLED	-/		N	/ A	
iled C	Hygi other ent, t	യ	17. Father's Name (First, Middle, Last	")			18. Mother's Nam	e (First, Middle,	Maiden	Surname)	<del>-</del>
ld be	ked ric ev	To B	CLARENCE OUELLET	ГЕ			GAYE M.	MAMOLIT	0		
shou	s mai		19a. Informant's Name/Relationship	(Type. Print)	19b.	Mailing Address (Street	and Number or Ru	ral Route Numbe	er, City o	or Town, State, Z	ip Code)
and 2	n 27 i		CLARENCE OUELLET	re / father		9 MAGOTHY B		PASADENA	, MA	ARYLAND	21122
les 1	if item		20a. Method of Disposition 1 □ Bunal 2 🛣 Cremation 3 □	☐Removal from State	20b. Place of cemeter	Disposition (Name of ry, crematory or other place	NOV.	Date 26,		ocation - City or	
. Pag	tant:		4 □ Donation 5 □ Other (Speci	fy)	METRO	CREMATORY,					E, MARYLAND
Derm	Department of Health and Mente Important: If Item 27 is marked any Injury or other traumatic evone.		21. Signature of Funeral Service Lice	nsee		KIRKLEY-RU 421 CRAIN	DDICK FUN HWY S.I	NERAL HO	ME, BUF	P.A. RNIE. MD	21061
٦.			23a. Part1. Enjer the disease, or com shock, or heart failure. List only			not enter the mode of dyin	ng, such as cardiac	or respiratory ar			Approximate Interval Between
Př	nysician		Immediate Cause (Final disease or condition	Acquire	D IN	IMUNE DE	FICIEN	c 7			Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a	consequence of	OFIL LYM	2011 0 0				- ded - de-
<u> </u>		-	Sequentially list conditions, if any, leading to immediate	b. LARG C Due to (or as a c			770797				
V. pet	nsit	nine	cause. Enter Underlying Cause (Disease or injury that initiated events			To 61	VER				
execu	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c							
icate be executed	physician and the burial-transit	dical	•	d							
rtifica	ng ph as th		IS SEMAN S.						Т		
S the	tendii or use	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1□Live birth 2		3 ☐Ectopic pregnanc	y			23d. Date of deli Month	very Day Year
e de	the at	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	me of death	5 ☐ Other (specify) _				WOILL	Day Four
that th	ed by detac		Part II. Other significant conditions								
i se	signe d be	by		contributing to death but	not resulting in	the underlying cause giv	ren in Part I.	23e. Did to	obacco	use contribute to	the cause of death?
				contributing to death but	not resulting in	the underlying cause giv	ren in Part I.			use contribute to	/
w redu	shoul			contributing to death but	not resulting in	the underlying cause giv	en in Part I.		res 2	No 3 Pro	obably 4 Unknown
The law requ	te has been age 2 shoul			contributing to death but	not resulting in	the underlying cause give	ren in Part I.	1 ☐ Y	res 2	24b. Were au	obably 4 Unknown topsy findings available ompletion of cause of
an: The law requ	rtificate has been tor, page 2 shoul	Completed	25. Was case referred to medical	contributing to death but	not resulting in	the underlying cause giv	ren in Part I.  26. Place of Dea	1   Y	an osy rmed? 2 \( \text{No.} \)	24b. Were au	obably 4 Unknown
ysician: The law requ	iis certificate has been director, page 2 shoul	o Be Completed		contributing to death but  Hospital: 1 □ Inpatient		Tour	26. Place of Dea	1 ☐ Y  24a. Was autop performed to the (Check only only only only only only only only	rmed?	24b. Were au prior to death?	obably 4 Onknown  topsy findings available ompletion of cause of
ng Physician: The law requ	ifer this certificate has been uneral director, page 2 shoul	To Be Completed	25. Was case referred to medical examiner? 1 ☐ Yes 2 1 No 27. Manner of Death	Hospital:	2 □ ER/Ou 28b. 1	tpatient 3 □ DOA Oth	26. Place of Dea ler: 4 X Nursing H y: 4 X Nursing H	1 ☐ Y  24a. Was autop performed to the (Check only only only only only only only only	rmed? 2 No	24b. Were au prior to c death? 1 □ Yes 6 □Other (Specific Prior Pr	obably 4 Onknown  topsy findings available ompletion of cause of
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State Registrar

NOV 2

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	•	For State Registrar	State of Marylai			te of Dea			Reg. No. 2	uu.	3. Tithe of Death
Physicia		1. Decedent's Name (First, Middle, Last)	sse //					2. Date of De Month Nover	. Day	5, 20	3. Tithe of Death.
/Medic Examin		4a. Fecility Name (If not institution, give st Holy Cross Rehab.	reet and number)		4b. City	Town, or Loca	tion of Death	lle		nty of Deat	
Funeral Director		559-70-3696	7. Age (In yrs	. last birthday) Yrs.	If Unde Months		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da 05/0	th ay, Year) 8/1955	9. Birt Co GA	hplace (State or Forei nuntry)
Maryland -f ahow lied at	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Anne Aru		ity, Town or Lo	cation				10d. Inside City Limit: 1  ☐ Yes 2  ☑ No		
with the	i Director	10e. Street and Number 7905 Chalice Rd.				p Code . <b>144</b> -			10g. Citizen o		
72 hours after death with the Maryland Instural; or Items 23s or 28s-f show Jical Exactinat must be ricilited at	by Funeral		2. Was Decedent Ever in a Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No If Yes, Give			Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☑ No Specify:			lace - Ame lack, Whit cify: Wh	
	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+)	(Give	kind of w DO NOT	ual Occupation ork done during use retired)	most of work	ing	16b. Kind of Feder		Andustry overnment
avant,	To Be Co	17. Father's Name (First, Middle, Last)  Dan Passell	4			J	ean Me				
ith and 27 is m r traum		19a. Informant's Name/Relationship (Type Joshua Passell/Brot	her	19 S	hatt	uck Rd.	nd Number or Rural Route Number, City or Town d. Watertown, MA 02472				
Department of Hee Important: if Item any injury or othe 2005		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, crea hesapea	natory or	ame of other place) remator	1	Nov 28 2007			Town, State , Maryland
Departimport		21. Signature of Funeral Service License  23a. Part1. Enter the disease, or complice	man		Rapp 933 G	ist Ave.	& Crema	ation Se er Sprin	g, Mary	land	20910-
Medical and burial-transit the burial-transit	dicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quanca of).							
ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1   Live birth 2   Fe 4   Pregnant at time ol 9   Unknown	tal death 3[	⊒Ectopic ⊒ Other (	pregnancy specify)		10.	23d.	Date of de Month	blivery Day Year
n signed by lid be deta	þ	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	ındərlying	cause given in	Part I.		tobacco use o		o the cause of death robably 4 □Unkr
cate has been signed by the attending page 2 should be detached for use as	Completed							perf	s an 24 opsy ormed? 2 10	prior to death?	utopsy lindings avai completion of cause s 2 No
this certificate	Be	25. Was case referred to medical examiner?	ospital:			Othor		th (Check only			
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within 24 hours after death.  To the Euneral Director: After completely filled in by the funer.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe		reet, lact	ory, office			(Street and No own, State)	umber or F	Rural Route Number,
24 hour Funeri etely fills	Medical (	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	iician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, dea nation and/or in	th occurre nvestigati	d at the time, d	ate and place n, death occu	, and due to the rred at the time	e cause(s) and , date and pla	d manner a ce, and du	as stated. se to the cause(s)
within To the	Me	29b. Signature and title of certifier	Soumo		2	9c. License nur		-		gned (Mor	oth, Day, Year)
6		30. Name and address of person who co	mpleted cause of death (It	em 23a) (Type 5 Sm	Print)	Avenu	0	- 1			e, Mdzizo
Sta	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sig		289						

State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 7 1- Steend #16a&20b Per FH G873 11/28/07tiffeate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25,2007 POLLACK **Physician** 6:44 PM ROSE November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/11/1915 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛱 F MD 92 215-09-3459 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location the Maryland 10a. State 28a-f show other treumetic event, the Mcdical Examinar must be notified at 1 ☐ Yes 2 No BALTIMORE BALTIMORE MD Director 10g. Citizen of What Country? 10f. Zip Code 21208 10e. Street and Number or Itams 23a or 4204 OLD MILFORD MILL ROAD Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death a nent of Heatth and Mental Hygiene. Int: If Item 27 is markad othar then "naturel", or Itams 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 🕅 No Specify: Specify: Baltimore, Maryland 21215-0036 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALEPERSON Salesperson RETAIL 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be UNOBTAINABLE DOBB UNOBTAINABLE UNOBTAINABLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 EMERALD RIDGE COURT - BALTIMORE, MD 21209 permit. Pages 1 and 2 Department of Health at Important: If Item 27 Is any Injury or other treu once. JEFF POLLACK / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Sodova 11/27/2007 ADATH YESHURUN BALTIMORE, MD ^ 4 ☐ Donation \_ 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of uneral Service Lice SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or competitations the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYPOXIA Pnysician /Medical Due to (or as a o blood pressure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Physiclan/Medical Examiner The law requires that the death certificate be executed as the burial-transit bowe Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE: usa 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 0 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2□ No 1 Yes 2 No certificate To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Manner of Death After t Certification: Natural 5 Pending investigation 1 🗌 Yes 2 No after death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 24 hours a 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 npleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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Registrar
DHMH 17 Rev 1/2001

State

ORIGINAL

6701 North Charles Street. Suite 6202 21204

Towson, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

Dr. Maw Naing Oo
31. Date filed (Month, Day, Year)

NOV 28

FERNANDO ANTONIO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

37905 2007

UNK UNI	K	_		State of Maryland	/ Departm	nent of Health cate of Death	n and Menta	reg.	No	
		R	For State egistrar . Decedent's Name (First, Mic	ddle Last)		Cate of Death		2 Date of Death		3. Time of Death
	Physicia Examir			1	٨	Rodri	uez	Month D October 29,	2007	1140 hrs
M	_Aaiiiii		Fernando la. Facility Name (if not institu	ution, give street and numbe	r)	4b. City, To	own, or Location of I		4c. County of D	eath
			5900 Radeke Avenu	ue		Baltim			N/A	. Birthplace (State or
F	uneral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last b	irthday) If Under	r 1 Year If Under 2		ĮF0	oreign Dominican Country Rep
	irector		062-769481	1 X M 2 F	35	Yrs.	Days Tiodis	Sept.16	,19/2	country) Rep.
		ŀ	Usual Residence of Decedent	t						10d. Inside City Limits
	any	Ī	10a. State 10b. Cour	•	10c. City, Tow					1 Yes 2 No
3	show nce.	5	Maryland	N/A	Bail	timore	Codo	100	. Citizen of What	· · · · · · · · · · · · · · · · · · ·
j	Aaryla 28a-f 1 at o	Director	10e. Street and Number			10f. Zip				SA
Ę	an the Na or	اقَ	5900 Radeke		15 110	13 Was Decede	21206	n? ( Specify Yes or No-	14. Race - A	American Indian, Black,
:	death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	11. Marital Status  1 Never Married 2	12. Was Decede Armed Force	es?	If Yes, specif	y Cuban, Mexican, I	Puerto Rican, etc.)	White, 6	itc.
	or ite	튑		1 Yes Divorced If Yes, Give Year	2 _X No	1 X Yes 2	No specify:		Specify:	white
	s after ral", niner	ą		or Dates: (Specify only highest grade of	completed) 16	n Decedent's Usual	Occupation (Give k		16b. Kind of Busin	ness/Industry
	hour "natu	ted	Elementary/Secondary (0-			during most of wor	rking life. DO NOT L	ise retired)		
36	nin 72 e. than dical	lple	12			Laborer_			Con:	struction
5-0036	d wit ygien other he Mo	Completed	17. Father's Name (First, Mic				18.Mother's	Name (First, Middle, M	alderi Surname)	Marakázaa
215	oe file ntal H rked c	Be	Felix		odrigue:	Z	(Chand and Num	ROSalia ber or Rural Route Num	ner. City or Town,	Martinez State, Zip Code)
2121	d Mer s mar	P	19a. Informant's Name/Rela					et #3D Bronz		
B	d 2 sh Ith an n 27 i		Alba	Rodriguez	Wife 20b. Pla	ice of Disposition (Na	me of cemetery,	Date	20c. Location - 0	City or Town, State
Baltimore, MD	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menhell Hygiens. In Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once, injury or other traumatic event, the Medical Examiner must be		20a. Method of Disposition  1 X Burial 2 Crem	nation 3 Removal from	n State Mun	matory or other place	etery	12/4/07	Santago	Dominican Rep
<u> </u>	Page nent c ant: or oth		4 Donation 5 Other	es Specify:		•		3111 Moun	tain Poa	d
älti	epartr nport ijury	1	21. Signature of Fun I Se	4		C+011;	nac Eunov	al Homo D	N Daca	dona MD 21122
ш		_	23a. Fart I. Enter Le Teas	se or complications that cau	ised the death. D	o not enter the mode	of dying, such as c	ardiac or respiratory arre	est, shock, or hea	rt Approximate Interval Between Onset and
19	/siciar /ledica		failure. List only one o	duse on each fie.		ead and left fore				Death
T E	xamine		Immediate Cause (Final dis or condition resulting in dea							
			Sequentially list conditions	h						
		je	if any, leading to immediate cause. Enter Underlying C	e Due to (or as a c	consequence of):					
	_	Examiner	(Disease or injury that initial events resulting in death)	ated Due to for as a c	consequence of):	:				
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	execu ian an	ica	UNPENDED	AMENDED					Tax no conf	deliver
60.	eath certificate be executed attending physician and for use as the hund a transit	Ched for use as the outland the Daysician Medical	IF FEMALE:		outcome of pregna	- 1 t t	y S Ecton	ic pregnancy	23d. Date of Month	Day Year
Box 68760.	ertific ding p	an /ue	23b. Was decedent pregnar past 12 months?		rth ant at time of dea	2 Fetal deal		io programs,	L.	
č	eath c	ior us	1 Yes 2 No 9	Unknown 9 Unkno	wn					in the table course of death?
	the d	cued 4	Part II. Other significant	conditions contributing to	death but not re	sulting in the underly	ing cause given in F			ribute to the cause of death?  Probably 4 Unknown
۵	s that	a deta								Were autopsy findings availab
۳	equire een si	ould						24a. Was	psy	prior to completion of cause of death?
Š	law r	, page 2 should be							of thoo.	Yes 2 No
O G Parande D	cian: The law requires that the de	filled in by the funeral director, page		medical			26.Place of Deat	h (Check only one)		
<u> </u>	sician sician	irecto	examiner?		Inpatient 2	ER/Outpatient 3	DOA Other	Nursing Home 5		✔ Other: Scene
2	OT VI	eral di	27 Manner of Death	28a Date	of Injury . Day,Year)	28b. Time of Injury	.28c. Injury at Wo	Subject wa	how injury occur as shot	red
2	ath.	he fur	1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	Pending Oct 29	Day,Year) 2007	FOUND: 1140 hrs	1 Yes 2	The second second	(Ctreat and Num	ber or Rural Route Number, C
:	IVISION or Attent after death Director:	n by t	Accident  Suicide 6	Could not be 28e. Place	ce of Injury - At ho	ome, farm, street, fac	tory, office building,	or Town	(Street and Num State) ke Ave, Baltime	
ä	ital o	Hedi	4 Homicide	determined (Specify)	Mini-van					
	LIVISION Of VICAL RECOLUS, T.O. DOX 901 20.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and	> 1		fying Physician: To the besical Examiner:On the basis	st of my knowled	ge, death occurred at	t the time, date and n my opinion, death	place, and due to the ca occurred at the time, da	use(s) and manne te and place, and	due to the cause(s)
	o the	completely	J 1	and mainter c	or examination a stated.	and/or investigation, if	29c. License numb	er	29d. Date sig	ned (Month, Day, Year)
4		°		1			O.C.M.E.		October 3	
	-			hi. m.			J.O.IVI.C.			
2	1			of person who completed cau	use of death (Item	<sup>n 23a)</sup> I Penn Street, B	altimore. MD 2	1201		
J			9	Assistant Medical Exa						
	De	Sta		2),	Registrar's Signat	Sparks				
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DHMH 17 Rev 1/2001

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/Medical Examiner o. Division or Vital Records,

sician and burial-trans use

Physician

Examine

Physician/Medical

Completed

Be

Certification: To

Medical

3 ☐ Suicide 4 Homicide

29a. Certifier

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

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or items

other traumatic event, the Medical Examiner must be

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

State Registrar

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

November 25, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print) Name and address of person

Sinay Hagital of Baltmore, Baltmore MD 21215

6 ☐ Could not be

32 Tegistrar's Signature

the

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Daniel **Physician** Jacob 1016mBER 21, 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or location of Death Examiner N/A Hopital Baltimone Sinai If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)

8 Yrs. 8. Date of Birth (Month, Day, 09/22 9. Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2□ F Months Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore 1 ☐ Yes 21 No Director 10f. Zip Code 10g. Citizen of What Country? IJSA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married アイルルン カS ブタ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) C & O Railroad Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be hendere Semble 19a. Informant's Name/Relationship (Type: Print) 19b. Mailing Address (Street and Number or Plural Boute Number, City or Town, State, Zip Code)
3115 Moravia Road Baltimore MD 21214 -Brodie/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Owings Mills, MD 11/28/07 Gamison Forest 22. Name and Address of Facility Vaughn C. Greene Funeral Senices 21. Signature of Funeral Service License sease, or complications that caused the death. Do not enter the mode of dying, sure. List only one cause on each line. 23a. Part1. Enter the shock, or hear Immediate Cause (Final disease or condition resulting in death) **Physician** ntrurn /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 □ Yes cate has been a 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performe this certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) 30. Name and ad 31. Date filed (Month, Day, gistrar's Signature Registrar

DHMH 17 Rev 1/2001

State

Registrar

Monroe

Hospital,

900 S. Caton

Ave', Baltimore, mo

21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fazeli,

31. Date filed (Month, Day, Year)

2

St. Agnes

32. Registrar's Signature

67

State Registrar Wayer

Year)

32. Registrar's Signature

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who completed cause of death (Item 23a) (Type, Print)

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			1 = For Amend Items 23 Registrar	a,PtI,25 I	yland/Depa per me,887	itment of F 13 11/20/	lealth and <b>07dhb</b> Death	Mental Hyg	gienez () ( Reg. No.	37911
	Physicia	an	Decedent's Name (First, Middle, Last)			0		2. Date of Dea Month	Day	3. Time of Death
	/Medic	al	Charles			4b. City, Town, o	11+h	Septemb	4c. County o	07 2337 PM
	Examin	er	4a. Facility Name (If not institution, give single The Johns Hopkin		1	Baltimor	-	->1/	1	VA
	Funeral		5. Social Security Number 6. Sex		'In yrs. last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth	h	9. Birthplace (State or Foreign
	Director		22/-13-3155	M 2□F	<b>44</b> Yrs.	Months Days	Hours Mir		3-1963	Country) Va.
	pue "		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	ō	Va. NA			pton				1 ∑Yes 2 □ No
	r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
	th with 23a o		107 East Pembroke	e Ave.		2366	59		USA	
	r deal	Funeral	11. Wartai Glatus	Was Decedent Every Armed Forces?	er in U.S. 13.1	Was Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race Black	- American Indian, , White, etc.
36	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examiner must be notified at	by Fi	1 ☐ Never Married 2∑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1⊡Yes 2√√2 No	Specify:		Specify:	Black
2-0036	thour atural	edt	15. Decedent's Educ	ation		dent's Usual Occup			16b. Kind of Bus	siness/Industry
2 2 2	:Ē ;; <b>⊆ ऑ</b>	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. i	kind of work done DO NOT use retired	during most of w d)	orking		
7	filed with Hygiene other the	Con		ōyrs.	I	structer			College	
land	d d d	Be	17. Father's Name ( <i>First, Middle, Last</i> ) <b>Charles</b>	E.	Smi+	h, Sr.	18. Mother's Na Odell	ame (First, Middle,	Maiden Surname Ever	* .
Š	d 2 should th and Men 7 is marke traumatic	은	19a. Informant's Name/Relationship (Typ					Rural Route Numbe		
Mary	d 2 7 is		Jeneane Smith	Wife		•		e., Hampt		236669
ē,	一工るを	- 3	20a. Method of Disposition		20b. Place of Dispo	sition (Name of	ce)	Date	20c. Location - 0	City or Town, State
Ē	e = ± e		1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other ( <i>Specify)</i>	emoval from State		Mem. Gard	1	-1-07	Hampto	n, Va.
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service License		22	2. Name and Addre	ss of Facility	March F.	H. East	
	20 E 20		Dranch Mille					. Baltin		
			23a. Part1. Enter the dis ase, or complic shock, or heart failure. List only on	eations that caused the cause on each line.	ie death. Do not ent	er the mode of dyli	ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis					-1-	7 days
	Examiner				consequence of):	infection				a days
	203	Jer	Sequentially list conditions, if any leading Lammadale cause. Enter Underlying Cause (Disease or injury		consequence of	MITCHION	/		1	2 ((20)
	cuted nd rransit	Examiner	that initiated events	cardino	arrest	Endocardi	tis /	1/1	Ph Chin	1-day
Š,	ificate be executed g physician and as the burial-transit	Ĕ	resulting in death) Last	Due to (or as a	consequence of):			ECHON APPOINT		
<b>6876</b> 0	ficate t physics ts the b	edical	d.				CERT	ElC.		
-		/Me	IF FEMALE: 23b. Was decedent pregnant	sc. If yes, outcome pf					23d. Date	e of delivery
. Box	The law requires that the death certif te has teen signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 🕅 No	1 Live birth 2 4 Pregnant at til		]Ectopic pregnanc; ]Other <i>(sp</i> ec <i>ify)</i> _	у	1	Mon	
J Ö	at the by the tache	hys	9 □ Unknown	9□Unknown						
	res tha	þ	Part II. Other significant conditions con		not resulting in the u	nderlying cause giv	en in Part I.			bute to the cause of death?
Vital Hecords,	requii een s hould	Completed	Chronic Renal ins	UMCIENCY				- 1 1	7	3 ☐ Probably 4 ☐ Unknown
9	2 2	mple						24a. Was autop	sy p	Vere autopsy findings available rior to completion of cause of eath?
g			25. Was case referred to medical				26 Pl 4 P	1∐ Yes	2 No 1	☐Yes 2 No
5	/sicia s certi	To Be	examiner?	ospital: 1 Inpatient	2 ☐ ER/Outpatier	nt 3□ DOA Oth	IOF.	eath <i>(Check only o</i> Home 5 Resid		er (Snecify)
יסר	ig Phy ter thi		27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time o				now injury occurre	- 1 / / //
<u>Ö</u>	endir sath. or: Af	atio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1□	Yes 2 □ No			
DIVISION	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc.	r - At home, farm, str ( <i>Specify</i> )	eet, factory, office		28f. Location (S City or Tox	Street and Numbe vn, State)	er or Rural Route Number,
_	spital ours a leral I		29a. Certifier 1 Certifying Phys	ician: To the best of	mv knowledge, deat	h occurred at the ti	me, date and pla	ce, and due to the	cause(s) and mar	nner as stated.
	ne Hos ne Fur detely	Medical			xamination and/or in					and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	26)-		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
1			Valalk	(00) MI	0	Res-	000		Septemb	per 25, 2007
(	3)	3	and address of person who con	mpleted cause of dea	th (Item 23a) (Type,	Print)				
		†a	Natalie Ruff 31. Date filed (Month, Day, Year)	320 Registrar	Nov+h	Wolf S	street,	Daltimos	e, MO	41287
	Sta Registr	_	NOV 2 0 200	7 Beren	H Ap	will				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2:55 P M 2007 11 22 Anita M. Sasscer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 11 7 1920 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Hours Min. 1 □ M 2 💢 F 87 Italy 218-01-0207 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X No Director Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 230 Register Ave 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Paint Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Campagnoli Lucy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Sasscer (son) 230 Register Ave Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview 4 □ Donation 5 □ Other (Specify) 11-23-2007 Baltimore 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Schimunek Funeral Homes, Inc. 9705 Belair Rd Nottingham, MD 21236 SIQUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) meddle cerebral Artery Lest cute week ue to (or as a consequence f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tension 1 🔲 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an was autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

**Examiner** law requires that the death certificate be execute g physician and as the burial-tran or Attending Physiclan:

**Physician** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Box 68760, asser,

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Division or Vital Records,

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	I by Physician/Medical	
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	completed	
	Be C	
П	2	
	ertification:	

1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

November 23,2007

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 8 2007

within 24 hours after death

To the Funeral Director:

completely filled in by the 1

within 24 hours a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. R. Ley G. BMC 6701 N. Charles SI. Balto Md 21204

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] ] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 2007 7:25A Nancy Irene Smith Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson If Under 1 Year Gilchrist Hospice Center Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) Age (In yrs. last birthday) (State or Foreign **Funeral** Months Days Hours 1□M 2 F 66 451.64.6655 Director 04.17.1941 TXUsual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ Yo Director Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A.

14. Race - American Indian,
Black, White, etc. 3328 Raccoon Ct 21009 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 D Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> <u>Own Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown <u>Unknown</u> Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 3328 Raccoon Ct. Abingdon, MD 21009

ce of Disposition (Name of Date 20c. Location - City or Town, State <u>Terri Smith/daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Cheasapeake Crem. 11.27.07 Beltsville, MD 22. Name and Address of Facility Cremation And Funeral Balto 21. Signafüre of Funeral Service Licensee Alternatives 8717 Green Pastures Dr. MD 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician monthe WOOM disease or condition resulting in death) /Medical (or as a consequence of): Examiner Novembe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IE FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1□Yes 2 No 9□Unknown Year Month Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Peath 28h Time of 28d. Describe how injury occurred Certification: 1 Matural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 26 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chances ST DONSUN My 21204 CHARLES, w 6701 32 Registrar's Signature Day, Year) 2007 31. Date filed (Month State Registrar

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cel</i>	aπment of F rtificate of			giene Reg. No 20 (	)7	37914
	Physici	an	1. Decedent's Name (First, Middle, Las	it)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	cal	George Sharpe  4a. Facility Name (If not institution, give	e street and number)		4h. City. Town. c	or Location of Death		aber 23,		12:00 PM
A	Examir	ier	Riderwood Retire	,	nity	, state of the sta	Silver		Monto		У
A.	Funeral Director		354-03-2847	ex 7. Age	(In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 06/26	th ay, Year) 6/1917	9. Birthpla Country IL	ce (State or Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				100	I. Inside City Limits
	a-f sh	ctor	MD Montgo	mery	Silver S	Spring					1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh		
	eath v is 23a must	Funeral	3116 Gracefield	Rd. #T12	ver in IIS 13.1	20904		nooify Von ar No	United	Stat - American	
920	d within 72 hours after death with the Maryland glene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces?  1 Mayes 2 □ No If Yes, Give Year or Dates:	0	If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Black Specify:	White, etc.	C.
5-0	72 ho 'natur dical I	eted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Deced	dent's Usual Occup kind of work done	oation during most of wor d)	king	16b. Kind of Bus		stry
21215-0036	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	DO NOT use retire sician	d)		Medica.	1	
land 2	be file ital Hy id othe event,	To Be Co	17. Father's Name (First, Middle, Last) Harry Sharpe	<del>_</del>			18. Mother's Nan Bertha	ne (First, Middle, Potash	l , Maiden Surname	)	
Maryland	ges 1 and 2 should be it of Health and Menta If item 27 Is marked or or other traumatic ev	<b> </b>	19a. Informant's Name/Relationship (						er, City or Town, S		Pode)
altimore,			20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Dispo cemetery, crer Chesape	osition (Name of matory or other pla ake Crema		Nov 26 2007	20c. Location - C	•	n, State Maryland
Balt	permit. Pa Departmer important: any Injury once.		21. Signature of Funeral Service Circe	pee Moo:	382 22	Name and Addre Rapp Fune 933 Gist	ess of Facility ral & Cres Ave. Silv	nation Se ver Sprin	ervices ng, Maryla	nd 20	910-
68760,	Physician //Medical Examiner as the burial-transit	edical Examiner	23a. Part1. Enter the disease, or composed in the control of the c	b. Due to (or as a Due to (or as a c.	Consequence of):			correspiratory a	rrest,	- 1	Approximate niterval Between Onset and Death
P.O. Box 68	The law requires that the death certifica te has been signed by the attending phage 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify)	у		23d. Date Mont		ay Year
S, D	es that gned b	by Pł	Part II. Other significant conditions of		· ·	nderlying cause giv	en in Part I.	23e. Did t	obacco use contrib	oute to the	cause of death?
ord	w requir been si should b	ted	DIABETES	MELLIT	us			10'	Yes 2. TNo 3	B ☐ Probat	oly 4 □Unknown
al Rec	: The law cate has b page 2 sl	Completed						24a. Was autop perfo 1∐ Yes	psy pr prmed2 de	ere autops ior to comp ath? Yes 2	y findings available pletion of cause of No
Zit	sician certifi irector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	t 2 ☐ ER/Outpatien	ot 3 DOA Oth	26. Place of Dea				
10	g Phy er this ieral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of	" OLI BOX	4 Li Nursing n		dence 6 □Other how injury occurre		
Division or Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		y - At home, farm, str	M 1 □	Yes 2 □ No	28f. Location (3	Street and Number	r or Rural I	Route Number,
	ospital o hours aft uneral Di ily filled in		29a. Certifier 1 Certifying Ph	ysiclan: To the best of niner: On the basis of e	my knowledge, death	h occurred at the ti	me, date and place	, and due to the	cause(s) and man	ner as stat	ted.
	thin 24	Medical	one)  29b. Signature and title of certific	and manner state	ed.	29c. Licens					
	7. ½ <b>5</b> . 0	-	255. dignature and title of certification	lun	fran		24093		Nov 2		
	641		30. Name and address of person who of MARK PARKHU	4 4 5-				8,,,,	ER SORI	va n	2007 ND 20905
	Sta Registr		31. Date filed (Month, Day, Year) NOV 2, 8, 2007		's Signature	les of	1	SC 1 LV	C/C 21.0.	2-[ 10	

			For State Registrar	State of Maryla	•	rtificate of		emarry	Reg. No 2	007	37915
	Physicia	an l	1. Decedent's Name (First, Middle, Last)				-	2. Date of De Month	ath Day	Year	3. Time of Death
3415	/Medic		Shirley L. Cofi		Shirle	y L. St		Nov	25	2007	9:09 Ам
	Examin	er	4a. Facility Name (If not institution, give s Sh. Agnes	Hospital		, , ,	or Location of Death	2	40. Cour	nty or Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In )	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	9. Birthp	place (State or Foreign
b	Director		212-34-6472	<sup>M 2</sup> ₹ 71	Yrs.	lyjoining Days	110010	08/19/		Maryl	
	land bw t	1	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary I-f sho	tor	Maryland		Ra <sup>3</sup>	Ltimore					YYes 2□No
	th the or 28a e noti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	ath wi		4124 Woodhaven Ave				21216		U.S.	A Race - Americ	an Indian
	er dea items ner m	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ▼No	n U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto	ecity Yes or No Rican, etc.)	)- 14. F	Black, White,	etc.
36	ırs aft al', or xami		3 ∑Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Spe	ecify: Blac	k
2-0036	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show art, the Medical Examiner must be notifled at	Completed by	15. Decedent's Educ (Specify only highest grade	cation	(Give	dent's Usual Occu	during most of worki	ina	16b. Kind of	f Business/In	dustry
21	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	Ü	Doo!	D-4-4	
Maryland 2121	iled w Hygie ther ti		17. Father's Name (First, Middle, Last)		Кез	alator	18. Mother's Name	(First, Middle		Estat	.e
an	d be ental ked o	To Be	Albert Watson				Clara Ma	vth			
ary	2 should and Mer is marke aumatic	-	19a. Informant's Name/Relationship (Type	oe. Print)	19b. Maili	ng Address (Stree	t and Number or Rura		er, City or To	wn, State, Zip	Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Antonio M. Stokes	/ Son	2405	N. Ellam	ont Stree	t, Balt	imore,	Maryl	and 21216 own, State
ore	Pages 1 nent of Hi int: If Iter iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20	b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Locatio	on - City or 1	own, State
Baltimore,	t. Partmen		4 Donation 5 □ Other (Specify)  21. Sign re of Funeral Service cense	lG	arrison	Forest C	eme. 12/05	/2007	Owings	Mills	, Maryland
Ba	permit. Pag Department Important: I any injury c		21. Signification of Fullerial Service Cherise	1.5	. 146	511 Dark	ess of Facility The Hgts. Ave	Derric	k C. J	ones F	'/H, P.A.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the o	death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory a	arrest,	Maryı	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A C	cute	Renal	Failur	e			Onset and Death
	/Medical		resulting in death)	Due to (or as a con							
Ě	Examiner	_	Sequentially list conditions,	Due to (Grae a con	piratio	n p	neumani	a			5 co sers
	nsit A	nine	lany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		tastati	c A	deno car	cinom	a		Zweeks
Ć.	execunary in and ial-tra	Еха	resulting in death) Last	Due to (or as a con	sequence of):						- 11100115
68760	rifilicate be executed ng physician and as the burial-transit	edical Examiner		. Pef	otic	ulcer	disea	se		-	zweeks
_	ertifica ling ph e as t		IF FEMALE:	On If was autoemo of mr	agnanay		-270			B	
80	eath c attenc for us	ian/	in the past 12 months?	3c. If yes, outcome pf pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	☐Ectopic pregnand	су		23d.	Date of deliv Month	Day Year
o.	the de y the	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□Unknown	or dodn'						
Division or Vital Records, P.O. Box	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Completed by Physician/IV	Part II. Other significant conditions con			ınderlying cause g	iven in Part I.				the cause of death?
ğ	equire en sig ould b	ed k	urinary tro	act infec	tion			10	Yes 2□N	o 3□ Pro	bably 4 🗹 Únknown
ec C	law r las be	ple	Anemia					24a. Was	psy	prior to co	opsy findings available ompletion of cause of
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Z.	siciar certif irector	Be C	25. Was case referred to medical examiner?	Hospital: 1 Vinpatient	2 ☐ ER/Outpatie	nt 3CLDOA Of	26. Place of Deat ther: 4 ☐ Nursing Ho			Other (Spec	ifu)
0	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time			28d. Describe			
ő	endlin ath. or: Aft	atio	1 ☑ Natural 5 ☐ Pending investigation	(month, bay rot	,,,,,,,,		]Yes 2 □ No				
ξ	or Att fler de Directe n by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - building, etc. (Sp		treet, factory, office	•	28f. Location City or To	(Street and Ni own, State)	umber or Rui	al Route Number,
	spital		29a. Certifier 1 Certifying Physics	sician: To the best of my	/ knowledge. dea	th occurred at the	time, date and place.	and due to the	e cause(s) and	d manner as	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical		ner: On the basis of exa and manner stated.							
	To th withir To th comp	Me	29b. Signature and title of certifler				nse number			gned (Month	
			Faren,				DP19513		NOV	25;	
	3		30. Name and address of person who co	eli , 900	(Item 23a) (Type S. Carto	n Ave.	Baltimor	e,mo	21229	24.48	nes Hospital
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's S		sach 1					

Shirley

Coffeeld - Stokes,

Physi	oian	1- State of I Per f Registrar  1. Decedent's Name (First, Middle, Last)	h, g874, 12/2		eaith and iv Death	2. Date of Dea		37916		
Physi /Med Exam	lical	4a. Facility Name (If not institution, give street and number		4b. City, Town, or I	_	Month	4c. County of Death	7- 7-709-M		
Funera Directo		212-38-4320 1 M 20 E	louse Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	olumbia  8. Date of Birth (Month, Day March 1		Howard  Iplace (State or Foreign  intry)  Virginia		
Maryland f show	- Jo	Usuel Residence of Decedent  10a. State 10b. County  Maryland Howard	10c. City, Town or Lo		Columbia			10d. Inside City Limits 1 ☐ Yes 2 No		
h with the P 3a or 28a-	ai Direct	10e. Street and Number 5400 Vantage Point Rd.		10f. Zip Code	21044	1	Og. Citizen of What Cou	untry? S.A.		
BAITIMORE, IMARYIANG 21213-UU35 permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event. The Medical Examinar must be publised.	Completed by Funeral Director	11. Marital Status  12. Was Decede Armed Force 1   Yes 2   1   Yes, Give 3   Widowed   Divorced   Year or Date	XNo	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 250 No	spanic Origin? (Spanic Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Bleck, White Specify:			
21215-0036  ed within 72 hours af giene. er than "natural; or i. the Wedfoal Exam.	ompleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) Supervisor of E	uring most of work		16b. Kind of Business/I	ndustry ucation		
Maryland 2 d 2 should be filed th and Mental Hygis 7 is marked other traumatic event.	To Be Co	17. Father's Name (First, Middle, Last)  Thomas Jefferson Sho			18. Mother's Name	e (First, Middle, i	Maiden Sumame) arrie Adams			
and 2 sho saith and n 27 is m	Ì	19a. Informant's Name/Relationship (Type, Print)  Ms. Ruth Shomo N		ng Address (Street ar 2839 Winches			r, City or Town, State, Z /A 22042	ip Code)		
altimore, mit. Pages 1 ar partment of Hea portant: If item	Ī	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Sta  4 Depnation 5 Other (Specify)	(e)	osition (Name of matory or other place view Cremato	)	Date 1/26/2007	20c. Location - City or 1 Baltim	own, State		
Physician	(	23. Part 1. Enter the disease, or implications that caus shock, or heart failure. List into one cause on each unmediate Cause (Final disease or condition	MLO 535 sed the death. Do not ent	3871 C ter the mode of dying,	Funeral Hom Old Columbia	Pike Ellico	tt City, MD 2104 est,	Approximate Interval Between Onset and Death		
ficate be executed it physician and its the burial-fransit		Indicate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if arily, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
es that the death certific igned by the attending p be detached for use as	Physiclan/Mec		2 Fetel death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of delin Month	very Day Year		
w requires that the tension of the t	þ	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause giver	n in Part I.		bacco use contribute to	the cause of death?		
Idi nec	e Completed	25. Was case referred to medical			26. Place of Deatl	24a. Was a autops perform	prior to c death? 2 No 1 Yes	opsy findings available ompletion of cause of		
To the Hospital or Attending Physician: The law requires that the death certificate the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	To B	examiner?  1 Yes 2 No Hospital: 1 Inp:  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	atient 2 ER/Outpatier njury Day Year) 28b. Time o Injury	nt 3 DOA Other	r: 4 ☐ Nursing Ho	me 5 Reside	ence 6 Other (Spec	ity)		
Hospital or Atte Hospital or Atte 24 hours atter de Funeral Directo	Certification;	4 Homicide Solominos building,	Injury - At home, farm, str etc. (Specify)			City or Town				
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one)  2   Medical Examiner: On the basis and manner  29b. Signature and title of certifier	s of examination and/or in stated.	vestigation, in my opi	nion, death occurr	red at the time, d	ate and place, and due	to the cause(s)		
D		30. Name and address of person who completed cause of Sco Princky	f death (Item 23a) (Type,	Print) / E	UN ET	H GE	EH, MIS	1201		
S Regis	tate	31. Date filed (Month, Day, Year) 32. Gegi	strar's Signature	Park 6		101-6		,		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Columbia Howard County General Hospital Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 219-42-6049 98 Director August 11, 1909 lowa Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 1 ☐ Yes 2 X No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21042 U.S.A. 3646 MacAlpine Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armyled Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armied Forces. Yes 2 No FYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 1943 1945 Specify: 3 Widowed 4 ☐ Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Security **Business Executive** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Int: If Item 27 Is marked of Leopold A. Stermole Mary Jevnik ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3165 Gorton Rd. NY, 14830 Corning Mr. Mark Stermole 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disp∮sition 20c. Location - City or Town, State 1 
☐ Burial 2 Cremation 3 ☐ Removal from State 11/26/07 Baltimore, MD **Bayview Crematory** 4 □ Donation 5 Other (Specify) rature of Funeral Service Licer 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death rmediate Cause (Final sease or condition sulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): after death.

I Director: After this certificate has been signed by the attending physician of the transfer of the britan director, nade 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⊠Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No Hospital or Attending Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 Yes 2 No Certification: To 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient filled in by the funeral 27. Manner of Death 28a, Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury (Month, Day Year) 5 ☐ Pending investigation M 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 701 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 8 31. Date filed (Month, Day, 32. Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

8 2007

07-09084 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Stewart, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0600 hrs Medical Examiner William H. Stewart, Jr. November 24, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4935 Valley View Overlook Ellicott City Howard If Under 1 Year If Under 24Hrs 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Director 193-30-9868 76 4/24/1931  $_{1}X_{M}$ 2 F Yrs Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 1 Yes 2 X No 28a-f show PA Delaware Upper Darby t: If item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, <u>the Medical Exa</u>min<u>er must be notified at once.</u> t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tment of Health and Mental Hygiene. Director 10e, Street and Number 10f. Zip Code 10q. Citizen of What Country? 19026 USA 4018 Berry Ave. Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 x Yes No Divorced If Yes, Give Yeer Korea 3 X Widowed Yes 2 X No spacify: Specify: White ξ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Construction Civil Engineer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) William H. stewart, Sr. Alvira Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4935 Valley View Overlook Ellicott City, MD 21043 William H. Stewart III son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/29/07 Drexel Hill, PA Arlington Cemetery mportant: Donation 5 Other Specify 22. Name and Address of Facility Slack F 871 Old Columbia Pike, Funeral Home, MD 21043 Signature of Funeral Service Licenses 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediata Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit Physician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Liva birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) for Yes 2 No 9 Unknown Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 No 3 Probably 4 V Unknown Aortic stenosis Completed director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? Yes 2 No Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other: DOA Nursing Home 5 Inpatient ER/Outpatient 3 Residence 6 V Other: Scene 1 Yes funeral After 28a. Date of Injury (Month, Dey, Yeer) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 No To the Funeral Director: completely filled in by the f Pending 2 Accident Investigation 28e. Placa of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 25, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 2007 NOV

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Registrar	State of Ma	aryland		artment of F				ne . №2 N I	n 7	270	10
21	Dhysisi		Decedent's Name (First, Middle, Last)						2. Date	of Death		Year	3. Time of	Death
Ē	Physicia /Medio		Sandra Dee Sw				0 02 T	.1	Nove	ember		007	3:40	АМ
18	Examin	er	4a. Facility Name (If not institution, give st Stella Maris				4b. City, Town, or Location of Death  Timonium					of Death	re	
4.	Funeral		Social Security Number     6. Sex			st birthday)	If Under 1 Year Months Days	If Under Hours	Min. (Mo.	of Birth	ear)		ace (State o.	r Foreign
	Director		218-82-5470 Usual Residence of Decedent	1VI 2,04.11	4	.5 Yrs.			Sep	t 29 <b>,</b>	1962	Mary	land	
	aryland show d at	_	10a. State 10b. County		10c. City,	Town or Lo						1	0d. Inside Cit 1 ☐ Yes	,
	the Ma 28a-f	Director	Maryland Baltimo  10e. Street end Number	re		Dui	ndalk 10f. Zip Code		****	100	. Citizen of V	What Coun		
	th with		8142 Dundalk Avenu	e			212	22				SA		
	tems ter mu	Funeral	11. Marital Status	2. Was Decedent E Armed Forces?		i. 13. \	Was Decedent of H	lispanic Or an, Mexica	rigin? (Specify Yes in, Puerto Rican, e	or No-		e - Americ k, White,		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ X If Yes, Give Year or Dates:	10		1 ☐ Yes 2 【XNo	Specify	:		Specify			
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212	filed with Hygiene. ther thar	Somp	Elementary/Secondary (0-12)	College (1-4or 5	+)		memaker				Own	Home		
and	d tal	Be	17. Father's Name (First, Middle, Last)						er's Name <i>(First, i</i>			10)		
aryi	nd 2 should be Ith and Mental 27 Is marked ( 27 Iraumatic ev	2	Arthur Sweitzer  19a. Informant's Name/Relationship (Type	e. Print)		19b. Mailir	ng Address (Street		ildred Si per or Rural Route			State, Zip	Code)	
Ž			Diane E. Wilhelm	, Sister			Searles				-			
Baltimore,	SOFE		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State			sition (Name of natory or other place	1	Date		c. Location -	•		,
	permit. Page Department of Important: If any Injury or once		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	9	Met	ro Cro	ematory I	nc.	11/26/0	/   1 Maxy1	Baltim	ore,	Maryla	and
ň	P a T P a	Thomas Gregor 299 Frederick Road Baltimore, Maryland									nd 212	28		
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	UTERINE	CANC	ER	er the mode of dyir	ng, such as	s cardiac or respira	atory arrest	i,		Approximate Interval Bett Onset and D	ween
	Examiner		Sequentially list conditions, b.	Due to (or as	a conseque	ence or):								
	ted nsit	Examiner	if any, leading to immediate Cause (Disease or injury	Due to (or es	a conseque	ence of):								
oʻ	e executed an and irial-transit	_	that initiated events c. resulting in death) Last	Due to (or as	a conseque	ence of):								
9/89	ate be hysici the bu	dical	d.											
ROX	leath certific attending p I for use as i	an/Me	23b. was decedent pregnant	c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy	,			23d. Dat	e of delive	ry	
j.	the deal by the att	Physician/Medical	in the past 12 months? 1 □ Yes 2 🕱 No 9 □ Unknown	4□Pregnant at 9□Unknown	time of dea	ath 5	Other (specify)				Mo	nth	Day Y	Year
S, T	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions cont	ributing to death bu	ut not result	ting in the u	nderlying cause giv	en in Part	1. 236	e. Did tobac	cco use contr 2∐ No			
ecords,	w requ	letec							248	a. Was an			osy findings	
Ï	The law ate has b page 2 sl	Completed								autopsy performe Yes 2	d?	orior to cor death?	npletion of ca 2 □ No	
VITa! H	slcian: The l certificate ha irector, page i	Be	25. Was case referred to medical examiner?	ospital:		70/0	t 3DDOA Oth		e of Death (Check					
n or	9 Hospital or Attending Physician: 24 hours after death. 5 Funeral Director: After this certificetely filled in by the funeral director,	ion: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injui (Month, Day	ry :	28b. Time of Injury	28c. Injur	y at k?			injury occurr		<u>) HOSP</u>	ICE
UIVISION	Attence death ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Płace of inju	iry - At hon	ne, farm, str	M 1 ☐ eet, factory, office	Yes 2 □ 	28f. Loc	ation (Stree	et and Numb	er or Rura	l Route Num	ber,
5	pital or urs afte eral Dii						a conveyed of the st							
	To the Hospital or Atten within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  Certifying Ph) in the control of the control one of the		examination		vestigation, in my o							i <b>)</b>
	To the within 2 To the complet	M	29b. Signature and title of certifier	-			29c. Licens	1 -	77.0	29d	. Date signed			
	,(		30. Name and address of person who con	nnleted cause of d	eath (Itom 1	23a) (Tuno		13	721		11/2	le/07	) 	
	η		DR. TARIQ MAHMOOD	2300 DU				'IMON]	CUM, MD 2	21093				
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu		2.66							
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DHMH 17 Rev 1/2001

07-09063

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dawn Shaulis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0317 hrs **Medical Examiner** November 23, 2007 Dawn Shaulis 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number **Funeral** 7. Age (In vrs. last birthday) oreign Days Hours Months Director Country Maryland 219-02-0521 M 2 X F 40 March 6 1967 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits any 28a-f show Yes 2 X No Harford Aberdeen Marvland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 102 Carol Street 21001 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 X Never Married 2 Married Yes ö f Yes, Give Year 2X No specify: Specify: White Widowed Divorced the Medical Examine ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than " MD 21215-0036 Carpet Cleaner Self Employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Lonnie L. Shaulis Ellen Lemaster 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1649 South Hanover Street Apt-A Baltimore, MD 21230 Lonnie L. Shaulis, 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Baltimore, crematory or other place) or other 1 Burial 2 X Cremation 3 Removal from State 11/26/07 Metro Crematory Inc. Baltimore, Maryland Donation 5 Other Specify 21. Signature of Funeral of Library Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and /Medical Death Narcotic intoxication (methadone) and cocaine use with Immediate Cause (Final disease a. ~xaminer or condition resulting in death) Due to (or as a consequence of): complications Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical tending physician a X UNPENDED AMENDED 7, 28a-f, perME, g874, 12/5/07 TT The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: 1 ✓ Inpatient 2 DOA ER/Outpatient 3 Nursing Home 5 Residence 6 1 ✓ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 X No 5 Pending unk FNd 11/22/2007 Fnd 4:30 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 X Could not be determined Suicide or Town, State)
102 Carroll St. Aberdeen, MD (Specify) Homicide residence 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. November 25, 2007 M. 30. Name and address of person who completed cause of death Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registra DHMH 17 Rev 1/2001 **OCME 2006** 

State

935 AR. 5

07-08975 Salif William Seydi

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Registrar	ate of Death	Reg. No. 2007 3792								
	Physici		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day November 20, 2007  S. Time of Death O745 hrs								
viec	lical Exami	ner	Salif William Seydi  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death									
233			12207 Acadeny Way # 10	Rockville	Montgomery								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24Hrs	. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign DISTRICT Of								
	Director		579-19-3209   1X M 2 F   2	O Yrs. Months Days Hours Min	April 5, 1987 Country Columbia								
			Usual Residence of Decedent										
(	w any	- '	10a. State 10b. County 10c. City, Town		10d. Inside City Limits								
Ó	Maryland 28a-f show d at once,	ţ	, ,	ockville	1 Yes 2 X No								
0	th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	10f. Zip Code 20852	10g. Citizen of What Country?								
	ith the 23a o notifi	무	12207 Academy Way, Unit # 10  11. Manital Status	13. Was Decedent of Hispanic Origin? ( Sp	USA pecify Yes or No- 14. Race - American Indian, Black,								
	eath w items ust be	Funeral	1 X Never Married 2 Married Armed Forces?	Rican, etc.) White, etc.									
	ifter d		3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify: White								
	hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	ed by	15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of vectoring most of working life. DO NOT use reti									
	C1 2 =	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)										
	withi	E	17. Father's Name (First, Middle, Last)	Student [18 Mother's Name	College (First, Middle, Maiden Surname)								
		Be	Ibrahim Seydi		cabeth Ervin								
	2121 ould be fi f Mental marked ic event,				Rural Route Number, City or Town, State, Zip Code)								
	MD d 2 sho lith and n 27 is numation				nit # 10 Rockville, MD 20852								
				of Disposition (Name of cemetery, ory or other place)	Date 20c. Location - City or Town, State								
	.도 집 원 등 등		4 Donation 5 Other Specify: Metro	Crematory Inc. 11/	26/07 Baltimore, Maryland								
	'Baltimore, permit. Pages I ar Department of Her Important: If ite		21. Signature of Funeral Similar Licensee Thomas Gregor	22. Name and Address of Facility Cremation Society	of Maryland, Inc. ad Baltimore, Maryland 21228								
	Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not	1 299 Frederick Roa	ad Baltimore, Maryland 21228 or respiratory arrest, shock, or heart Approximate Interval								
	/Medical		failure. List only one cause on each line.	one of the state o	Between Onset and Death								
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			Sequentially list conditions, b										
		i.	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause										
	- t	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
	of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed Wher this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - trans		d.										
	760, cate be execut physician and the burial - tra	Medical	X UNPENDED AMENDED #23a PTT 27 perME of	374. 12/13/07 TT	Andrew Commence of the Commenc								
	68760, certificate be rding physici se as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2		23d. Date of delivery ancy Month Day Year								
	Box 68 death certif the attending ed for use as	Sicie	4 Pregnant at time of death										
	O. Bo	Physician	Part II. Other significant conditions contributing to death but not resulting	s in the underlying course given in Port I	23e. Did tobacco use contribute to the cause of death?								
	ires that the signed by be detach		Diabetes mellitus	g in the underlying cause given in Fart i.	1 Yes 2 No 3 Probably 4 V Unknown								
	ords, I w requires us been sig should be	Completed by			24a. Was an 24b. Were autopsy findings available								
	COF law r has b e 2 sh	ם		<del></del> -	autopsy prior to completion of cause of death?								
	tal Rec cian: The l certificate l ector, page		25. Was case referred to medical	26.Place of Death (Check	1 V Yes 2 No 1 V Yes 2 No								
	Vital F hysician: this certifi al director,	Be	examiner? Hospital: 1 Inneticet 2 FR/O	Othor:	ng Home 5 Residence 6 ✔ Other: Scene								
	I of Vital Records, P.O. ing Physician: The law requires that the Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detaction;	٤	27. Manner of Death 28a. Date of Injury 28b.	Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred								
		흹	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No									
	Division tal or Attendii rs after death. al Director:  ded in by the fu	<u>≅</u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	spital tours a	Certification:	4 Homicide determined (Specify)	· ·									
	Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dec (Check only one)  2 Medical Examiner: On the basis of examination and/or in										
	To To To Com	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								
			701.	O.C.M.E.	November 21, 2007								
Į,		}	30. Name and address of person who completed cause of leath (Item 23e)										
				11 Penn Street, Baltimore, MD 21	201								
			31. Date filed (Month, Day, Year) NOV 2 8 2007	Specker									
	Regist	ueli	MOVE O COOL	7									

**Physician** /Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Division or Vital Records, P.O. Box 68760 attending pl

Physician

/Medical

**Examiner** 

**Funeral** 

Director

Items 23a or 28a-f show ner must be notified at

r than "natural", or Items 23a the Medical Examiner must

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'a any injury or other traumatic event, the Meonee.

Director

Funeral

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Completed

Be

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MD

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

signed by the a d be detached f s certificate has be irector, page 2 s within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

	Sequentially list conditions	Due to (or as a consect					Year				
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	23d. Date of de Month	elivery Day Year							
ted by Pr	Part II. Other significant conditions of	ontributing to death but not res			23e. Did tobacc		o the cause of death?  robably 4 □Unknown				
Comple					24a. Was an autopsy performed	death?	utopsy findings available completion of cause of s 2□ No				
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
0	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 □Other (Spe	ecify)				
ation:	27. Manner of Death 1		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred					
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fac fy)	28f. Location (Street City or Town, Sta	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
edical	29a. Certifier Check only one) Certifying Physics Medical Exam	ysician: To the best of my knoniner: On the basis of examinated and manner stated.	owledge, death occurration and/or investigat	ed at the time, date and place ion, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)				
ğ	29b. Signature and title of certifier			29c. License number	29d. I	29d. Date signed (Month, Day, Year)					
	M	lum		000470	/	11/25/0	7				

State Registrar wany lake M. Balls MM 21269

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2700

orrar's Signature

S( II MACINULA ed (Month, Day, Year)

31. Date filed (Month, Day,

			Hegistrar		Oei	tineate of L	Journ		Heg. No.		
	Physici		Decedent's Name (First, Middle, La SANDRA	st)		SKOLN	IK	2. Date of D Month November	Day	Year	3. Time of Death
100	/Medio		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or				y of Death	
•	Examili	ler	KESWICK MULTI-CA	•		BALTIMOR				/A	
- 11 - 12 - 13 - 13 - 13 - 13 - 13 - 13 - 13 - 13	- Function		5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year		8. Date of B	irth		lace (State or Foreign
	Funeral Director		216-34-6941 Usual Residence of Decedent	ПМ ЗПЕ	69 Yrs.	Months Days	Hours Min.	01/23/	<sup>7</sup> 1938	NY NY	<del>MY</del>
	and w		10a. State 10b. County	100	c. City, Town or Lo	cation				1	0d. Inside City Limits
	sho sho	'n									1 V Yes 2 No
	he M 18a-f otifie	ecto	MD N/	A	BALTIM				10 000		
	with the	Director	10e. Street and Number 2415 EVERTON RO	AD		10f. Zip Code 21209			10g. Citizen of	S.A.	itry?
	eath IS 23 nusi	era		12. Was Decedent Ever	in II S 13 1		spanic Origin? /Sr	nacify Vas or N		ce - America	an Indian
215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitied at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Tyes 2 No If Yes, Give X Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Bla Specia	ick, White,	
Š	2 ho	ted	15. Decedent's E		16a. Dece	dent's Usual Occupa	ation		16b. Kind of E		
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פ	other Jent, tt	Be C	17. Father's Name (First, Middle, Last	)			18. Mother's Nam	e (First, Middl	e, Maiden Surna	me)	
ā	should be nd Mental marked o	To B	UNKNOWN		MORR	ISON	JULIA		KI	LEIN	
Maryland 21	should ind Men marke umatic		19a. Informant's Name/Relationship (	Type. Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Num	ber, City or Town	, State, Zip	Code)
	nd 2 alth a 27 ls r tra	. 3	LEONARD SKOLNIK /	HUSBAND	2415	<b>EVERTON</b>	ROAD - B	ALTIMOR	RE, MD. 2	21209	
ē,	s 1 and if Healt item 2		20a. Method of Disposition	2	0b. Place of Dispo	osition (Name of	١	Date	20c. Location	- City or To	wn, State
altimore,	e = 5		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of the Contro	Removal from State	BETH TFI	LOH CONG.	11/2	5/2007	BALTIMO	RE, MI	)
	nit. Pag artment ortant: injury o		21 Signature of Funeral Service Lice		22	2. Name and Addres	s of Facility C	OL LEVI	NSON & I	RROS	TNC
n	permit. Departr Importa any inji		1 70 + - LM	X	ľ	8900 REIS					
			23a. Part1. Enter the disease, o	plications that caused the						,	Approximate
	4 2		shock, or heart failure. List only Immediate Cause (Final	one cause on each							Interval Between Onset and Death
į	Physician /Medical		disease or condition resulting in death)	a Squama	in cell -	lung car	icer mit	h lione	g wroun		Hear
	Examiner			Due to (or as a cor	nsequence of):		met	astase	15		
		1	Se ventially list conditions if any, leading to immediate	b. Due to (or as a cor	nsequence of):					-	
7	led Isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Duc to (0/ 40 4 00/	nooquonoo oi).						
	certificate be executed rding physician and ise as the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a cor	s a consequence of):						
Ď Q	be ex			2 40 10 (0. 40 40 40							
P8/P0	ate hys	dic		▲d							
و ×	tth certific tending pl	an/Medical	IF FEMALE:	Ode Muse suteems of no							
XO	eath c attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pr 1 Live birth 2	Fetal death 3					ate of delive Ionth	ery Day Year
<b>.</b>	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at time 9☐Unknown	of death 5	Other (specify)					
7.	d by etach	Physici	The state of the s		ė unacidžinas imėlas co		an in Dark I	220 Die	I tobooce use see		an acusa of death?
ŝ	The law requires that the death tte has been signed by the atten age 2 should be detached for u	by	Part II. Other significant conditions	onthouting to death but no	resuling in the u	nderlying cause give	en in Fan i.				ne cause of death?
5	equi sen s	Completed						1	Yes 2 No	3 ☐ Prob	ably 4 Unknown
ပ္သ	law i	ple						24a. Wa	s an 24b.	Were auto	psy findings available mpletion of cause of
ř	The transfer age	E O						per 1□ Yes	formed?	death?	2 □ No
Ital Records,	sician: The law certificate has l irector, page 2 s	Be C	25. Was case referred to medical				26. Place of Dea				
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatier	nt 3 DOA Othe	ar.		sidence 6 □Ot	her (Specif	v)
<u></u>	g Physer this eral di		27. Mann of Death	28a. Date of Injury	28b. Time o				how injury occu	<del></del>	
0	nding I th. : After e funer	ţi	1 √ atural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injury		Yes 2 □ No				
VISION	Attending r death. ector: After by the fune	lica	3 ☐ Suicide 6 ☐ Could not b	Zoe. Flace of figury -		reet, factory, office			(Street and Num	ber or Rura	I Route Number,
5	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 Homicide determined	building, etc. (S	ресіту)			City or T	own, State)		
	spite lours neral		29a. Certifier 1 Certifying Pl	nysician: To the best of my	y knowledge, deat	h occurred at the tin	ne, date and place	, and due to th	e cause(s) and m	nanner as s	tated.
	24 h 24 h e Fui etely	Medical	(Check only 2 Medical Example)	niner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my o	pinion, death occu	rred at the time	e, date and place	, and due to	the cause(s)
	o th	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sign	ed (Month,	Day, Year)
L.	⊢ > ⊢ ō		D. Balyle. VI	20 000	12 20	7126	7		4 .	,	1 11007

State Registrar

MISMELLE

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MOEGREGOR, TEOW. 40 th STREET, BALTIMORE, ON 21211

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Nicht AS

			Flea	State of			artment of I				•	Die.	
			1 - For State Registrar	Olate C	i waiyiari	•	rtificate of		aria ivi		20	7	37924
			Decedent's Name (First, Middle	e, Last)		-		-		2. Date of Dea		Year	3. Time of Death
	Physici /Medi		ESTHER			SI	EGEL			MOY	252	00)	430 M
4	Examir	ner	4a. Facility Name (If not institution JEWISH CONVALE				4b. City, Town, BALTIM		of Death		4c. County	of Death	). W =
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
	Director		212-03-9412	1□M 2√F	93	Yrs.	Months Days	Hours	Min.	8. Date of Birth Month, Day 12/21/	1913	Coun	VA
	land bw		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				_	1	0d. Inside City Limits
	Mary a-f sh	tor	MD BAL	TIMORE		OWI	NGS MILL	S					1 ☐ Yes 2 No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other then "neturel", or items 23e or 28a-f show or other traumatic event, the Madical Examinar must be notified at or other traumatic event, the Madical Examinar must be notified at	Completed by Funeral Director	10e. Street and Number 4600 ALCOTT WA	V #106			10f. Zip Code	117			0g. Citizen of \	What Cour	ntry?
	ns 236	eral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.			gin? (Spec	cify Yes or No-		e - Americ	an Indian,
9	or Iter or Iter miner	Fun	1 ☐ Never Married 2 ☐ Mar	ried 1 Tyes If Yes, Gi	2 No	1	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No			Rican, etc.)	Specifi	ck, White,	etc. WHITE
21215-0036	hours urel',	d by	3 Widowed 4 □ Divorced	Year or E	Dates:								
-51-2	n "net	plete	(Specify only highe	nt's Education st grade completed)	1.40= 5.1	(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during mosi ad)	t of workin	g	16b. Kind of B	usiness/ind	austry
212	filed with Hygiene. Ather ther	Com	Elementary/Secondary (0-12)	College (	1-401 5+)	COMM	ERCIAL A	RTIST			RE	TAIL	
Maryland	ould be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, LOUIS	Last)		BATE	S	18. Mothe		(First, Middle,	Maiden Suman		DLER
aryl	2 should and Men Is marke aumatic	P	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address (Stree	t and Numbe	er or Rural	Route Numbe	r, City or Town,	State, Zip	Code)
	1 and 2 Health a tem 27 is		SALLY ENGLE /	DAUGHTER			ALCOTT				MILLS,	MD :	21117
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any Injury or other tr once.		20a. Method of Disposition 1 → Burial 2 ☐ Cremation		State OLIE	lace of Dispo emetery, crei	sition (Name of matory or other pla	(CO)		/2007	REISTER	,	
Itim	Part Ary		* 4 Docation 5 □ Other (S	0:1//	Onei	) JIIAL	OM MEMOR	ARK   -	v SOI	1 FV TNS			
B	permit. Departr Importe any Inji		8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208										
			23a. Part f. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between										Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a a	culi	My,	resde	el.	en	fun			< 15min
	Examiner		WOON COMPANY STANCES	Co	(or as a consequence of the cons	uence oi):	astory	Dis	Scer	ie.		-	Thomash
7	p #	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a conseq	uence of):							7/0,014
V_	e be executed /sician and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	Ar as a consequence	tence of):	600						16maria
760	eath certificate be executed attending physician and for use as the burial-transit	calE		d	<i>'</i>								
.89	ing ph	Medi	IF FEMALE:	1							1		
Вох	attend for us	Physiclan/Medi	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live I	tcome of pregna birth 2 ☐ Feta nant at time of d	Ideath 3[	Ectopic pregnand Other (specify)	ey .				te of delive onth	ery Day Year
P.O.	that the de ed by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn		04	_ caron (opcony) _						
S, F	uires tha signed l d be det		Part II. Other significant conditi		leath but not resi	- //	nderlying cause gr	ven in Part I.					ne cause of death?
Records,	w requir been si should I	eted	_ Creu isca	7 4 40	cha			) —			es 2□No	3 ☐ Prob	
Rec	eicien: The law certificate has b irector, page 2 s	Completed by								24a. Was a autop: perfor	sy med <sub>2</sub> ?	prior to cor death?	psy findings available impletion of cause of
Vital	ien: T	Be C	25. Was case referred to medica examiner?	1				26. Place	of Death	1 ☐ Yes (Check only of	A	1 🗆 Yes	2 L No
of V	Phyeic this ce al dire	은	1 ☐ Yes 2 No			ER/Outpatier	it 3 DOA				ence 6 Oth		y)
on	ding F th. After funer	tlon	27. Magner of Death  1 Natural 5 Pendii 2 Accident investi		of Injury oth, Day Year)	28b. Time o Injury	Wo	iryat ork? ]Yes 2.⊟l		8d. Describe n	ow injury occur	red	
Division	er death.	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At ho ing, etc. (Specify	ome, farm, sti	eet, factory, office		2	8f. Location (S City or Tow		er or Aura	I Route Number,
ā	oitel or urs afte rel Dii						and the same of th						
	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier / Certifyii (Check only 2 Medical one)	ng Physician: To the Examiner: On the b and man	e best of my kno easis of examina ener stated.	wledge, deat tion and/or in	h occurred at the t vestigation, in my	ime, date an opinion, dea	id place, a th occurre	nd due to the d d at the time, d	ause(s) and ma late and place,	anner as st and due to	tated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifie	or .	MA		29c. Licen	se number	10:	2	9d. Date signe	*	
	1		Muly	em'	( )		1000	449	817		MOY	26	2007.
	4		30. Name and address of person	to completed cau	se of death (Item	23a) (Type,	Print) Lo	Rela	ne e	lero a	we	Ba	Thinkore
	Sta		31. Date filed (Month, Day, Year,		istrar's Signa	ture	1-1-	,			/	,-	- 12
DI.	Registr		NOV 2	8 2007	Ester.	S. A	parti						

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** STIVA 0310 2007 Antonio /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** medical center VA | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 29, 1922 Biltimare Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1**№**M 2□F Massachusetts 023-12-7639 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 28a-f show 1 □Yes 2 No notified Director Elkridge Maryland Howard permit. Pages 1 and 2 should be filed within 72 hours after death with the A Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" ~~ "... any injury or other traumatic event." 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21075 U.S.A. 6257 Sandpiper Court Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ▼Yes 2 □ No If Yes, Give 11 Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify. Black 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Private Merchant Marine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paulina DaSilva Moayses Silva 19a. Informant's Name/Relationship (Type. Pript) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6257 Sandpiper Court Patricia S. Franklin Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 □Removal from State Owings Mills, MD Garrison Forest 11-29-2007 4 Donation 5 Other (Specify) Witzke Funeral Homes, Inc 5555 Twin Knolls Road Co 21. Signatura of Funeral Service License Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 Days Due to (or as a consequence of): **Physician** Pheumonitis /Medical Examiner wee ky Decline in Menta Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Vascular ischemia Infection mi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ◆ Unknown CRACEMAKE + CABO Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an removal UT autopsy performed? Yes 212 No certificate has birector, page 2 s 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 1 Minpatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AU 417 6435 T 18183 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +1 M.D. Bultimore Minghen Leo 10 N. Gyere street

State Registrar 31. Date filed (Month, Day, Year)

NOV 28

2007

32. Registrar's Signature

		Decedent's Name (First, I		State of Ma per Fh,g							2. Date of De	ath		3 7 9 2 3. Time of Deat
nysiciar	_	Mary	I	Eva	Szr	rom				7	Month Novemb		20,2007	1:00 P
Medica xamine		Ia. Facility Name (If not inst	itution, give	e street and number)			4b. City, Tov	νπ, or L	ocation of		VOVEIN		c. County of Death	
tallilli.		805 S. Fount	ain (	Green Rd.			Bel F	Air				I	Harford	
neral		5. Social Security Number	6. S	ex 7. Ag	e (In yrs. last		If Under 1 Y Months D	'ear ays	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	thLZ/ iy, Yea	// 1993 <del>61</del> nh	place (State or For
ector		212-34-0012		□м 25Д F	72	Yrs.					Dec. 1	2,	<del>1934+</del> Mar	yland
257	-	Usual Residence of Decede  10a. State 10b. Co			10c. City, T	own or Loc	ation							10d. Inside City Lin
la pa			ford		Bel									1 □Yes 2.
H H	ect	10e. Street and Number	LICIU		DOI	1144	10f. Zip Co	ode				10a. C	Citizen of What Cou	untry?
20 6	בַּ			O D	. a									,
must	era 	805 S. Four	ntain	12. Was Decedent		13. W		015 t of His	panic Orio	in? (Spec	cify Yes or N	<u>U</u> ;	14. Race - Amer	ican Indian,
other traumatic event, the Medical Examinar must be nutited at	by Funeral Director	1 Never Married 2		Armed Forces?  1  Yes 2 !!  If Yes, Give  Year or Dates:	,		Yes, specify ☐ Yes 2	-	, Mexican, Specify:	Puerto P	cify Yes or Ne lican, etc.)		Black, White	, etc. Vhite
al a	- B		edent's Ed		1	I6a. Decede	ent's Usual C	occupat	tion			16b.	Kind of Business/I	ndustry
Albert	Completed	(Specify only	highest gra	ide completed)	F.\\	(Give k life. D	ind of work of ONOT use r	done du retired)	ıring most	of workin	g			
9	Ē	Elementary/Secondary (0 1.2	-12)	College (1-4or 5		Lette	r Carı	rier	<b>c</b>			U	.S. Posta	al Servic
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raumatic sv	To Be	Anthony V								ophi	0	_	ssi-	
T T	-	19a. Informant's Name/Rela	ationship (	Type, Print)		19b. Mailing	g Address (S	treet ar	nd Numbe	r or Rural	Route Numb	er, City	or Town, State, Z	ip Code)
1		Mary A. Smi	+h /	Daughter		3423	Grier	Mar	cerv	Road	1. Str	ent	. Marvlar	d 21154
r other tre	1	20a. Method of Disposition	1	Langiter	20b. Place	e of Dispos	sition (Name latory or othe	of	-		ate		Location - City or	
		1 ⊠ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ott			'   _	_				1 24	07	Λh	erdeen, N	hre lunc
any injury or	1	21. Signature of Funeral Se			Bake		Name and			1-24			erdeen, r	aryranu
eny ir		Mester	111	Hugele		MC 13	Comas	Fur	neral	HOM	e, P.A	m-low	n, Maryla	nd 21000
	-	23a. Part1. Enter the disea	se, or com	plications that caused	d the death. I	Do not ente	or the mode of	of dying	, such as	cardiac or	respiratory	arrest,	I MILYTE	Approximate
		shock, or heart failure Immediate Cause (Final	. List only	one cause on each li	ine.	3 .								Onset and Dea
ician dical		disease or condition resulting in death)	_	a	iasta	tic	De	91	rav		and	0		Smon
niner			- (	Due to (or as	a consequen	nce of):								
	ē	Sequentially list conditions if any leading to immediate		b. Due to (or as	a consequen	nce of):								
	를	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	` ⊀	(	,	,-								
2	5 1			C									- 3	
al-trans	X	that initiated events resulting in death) Last		Due to (or as	a consequen	nce of):							1	
2 2	al Examin	that mhated events			a consequen	nce of):								
ng price	ca	that mhated events	l	Due to (or as	a consequen	nce of):								
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			For State Registrar	State of Maryland	d / Depa <i>Cel</i>	artment of H rtificate of I	lealth and Mer <i>Death</i>		iene2007	37927
		8	1. Decedent's Name (First, Middle, La	st)		_	2.	Date of Dea Month	th Day Year	3. Time of Death
n sin	Physici /Medi	-	Helen A. Tay	lor		Y***	No		r 23, 2007	8:14 A. M
	Examir	- 1	4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, or	r Location of Death		4c. County of Dea	ath
			1077 Omar Drive			Crownsvi			Anne Ar	
	Funeral Director		5. Social Security Number 6. S 102–12–9194	Sex 7. Age (In yrs. It I□M 2XXF 84	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day	, Year) C	rthplace (State or Foreign country) York
	nud w		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	ocation				10d. Inside City Limits
	h with the Maryla 23a or 28a-f shov st be notifled at	7		Cl	en Bur					1 □Yes 2√□No
		Director	Maryland Anne A	Arundel GI	en bar	10f. Zip Code		1	log. Citizen of What C	country?
			437 Rogers Ave			21060			United St	ates
	deat ems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (Specify an, Mexican, Puerto Ric	Yes or No-	14. Race - Am Black, Wh	
980	be filed within 72 hours after death with the Maryland that Hygiene.  9d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 27 No If Yes, Give Year or Dates:		1⊡Yes 2∏XNo	Specify:	,		White
Ö		ted	15. Decedent's E. (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	eation		16b. Kind of Busines	s/Industry
d 21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		naker	during most of working d)		Own Home	
			17. Father's Name (First, Middle, Last	")			18. Mother's Name (F	irst, Middle,	Maiden Surname)	
an	0 0 0	To Be	Richard Henry Hall Daisy May Bennett							
Maryland	07	-	19a. Informant's Name/Relationship			,	and Number or Rural R	oute Numbe	r, City or Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		James M. Taylor / Son 203 Kent Road Glen Burnie, MD 21060							
Baltimore,	ages 1 ar nt of Hea : If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cre	osition (Name of matory or other place	1 210 1		20c. Location - City of	
Ħ	it. Partmenrtant		4 □Donation 5 □Other (Specify) Meadowridge Mem. Pk. 2007 Elkridge, Mar  21. Signatury of Funeral Service Licensee 22. Name and Address of Facility							
Ва	permit. Pages 'Department of H Important: If Ite any Injury or of		Jou & Cha	avy (	4.	irkley-Ru 21 Crain	ddick Funer Hwy. S.E. (			21061
4			23a. Part1. Enter the disease, or com shock, or heart failure. List only	nplications that caused the death	n. Do not en	ter the mode of dyir	ng, such as cardiac or re	espiratory ari	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Dementia						Onset and Death
-	/Medical		resulting in death)	Due to (or as a consequ	ence of):					
	Examiner		Cognosticily list conditions	Hypertensi	on					yrs.
	D =	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ						·
10	executed in and ial-transit	Examine	Cause (Disease or injury that initiated events	cAtrial Fir	billat	ion				yrs.
0,7		-	resulting in death) Last	Due to (or as a consequ		- ·				
09289	ate be hysici the bu	lical		Coronary A	rtery	Disease				yrs.
P.O. Box 6	law requires that the death certificate be as been signed by the attending physicia 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify) _	y		23d. Date of d Month	elivery Day Year
	s that ned b deta		Part II. Other significant conditions	contributing to death but not resu	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ecords,	w requires that the deben signed by the should be detached	ed by	Lt. hemiplegia,	chronic renal	failu	ıre,		1 🗆 Y	′es 2 No 3	Probably 4 Unknown
Diabetes type II							24a. Was a		autopsy findings available completion of cause of	

Division or Vital Records, P.O. Box 68760, ちょ To the Hospital or Attending Physician: The within 24 hours lifer death.

To the Funeral Director: After this certificate his completely filled in by the funeral director, page Medical Certification: To Be Corr

9 ∐ Unknov	/n	323 OHMOWII						
Part II. Other sig	nificant conditions	contributing to death but not res	sulting in the underlying	cause given in	Part I.	23e. Did tobacco u	se contribute to the cause of death?	
Lt. he	emiplegia,	chronic renal	l failure,			1 Tes 2	□ No 3 □ Probably 4▼□Unknown	
Diabet	es type I	I				24a. Was an autopsy performed? 1☐ Yes 2☐ No	24b. Were autopsy findings available prior to completion of cause of death?  1   Yes   2   No   1   3   4   5   6   6   6   6   6   6   6   6   6	
25. Was case ref	erred to medical			(Check only one)				
examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3□ [	e 5 Residence	Nother (Specify)			
27. Manner of De 1 X Natural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	28 2 □ No	3d. Describe how injur	y occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				18f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one)		nysician: To the best of my kn miner: On the basis of examin and manner stated.					and manner as stated. d place, and due to the cause(s)	

State Registrar

30. Name and address of person who completed cause of death (kep 23a) (Type, Print) Allen Reilly, M.D. 801 Toll House Ave. Allen Reilly, M.D.
31. Date filed (Month, Day, Year)

29c. License number D54749

29d. Date signed (Month, Day, Year) November 23, 2007

House Ave. D-1 21270 Frederick, MD

29b. Signature and title of certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Deat 4a. Facility Name (If not institution, give street and number) Examiner 110 Grove 10ml 5. Social Security Number Year | if Under 24 Hrs. 9. Buthplace (State or Foreign ge (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 X F Months Days Director Afghanistan 218-13-4613 5, <u>June</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a 11401 Hawks Ridge Terrace 20876 India Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 NWidowed 4 □ Divorced "natural", Asian-Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Fisher is marked of Patasha Aatmi Malhotra ည Ram 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trat once. Ram Vig/son 11401 Hawks Ridge Terrace Germantown, Maryland20876 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 11/28/2007 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) W Arundel Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A 1411 Annapolis Road Odenton, Maryland 21113 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** e ans /Medical Due to (or as a consequence of) Examiner Sequentially list conditions e to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 E No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 √0 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Muaubo 3 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year NOVEMBER 19, 2007 **Physician** DOLORES CHARLOTTE VENKER 18:58 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ XF Director 220-14-3329 Maryland July 5, 1925 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐No Examiner must be notified Director 28a-f Maryland\_ Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 Laburnum Road items 23a 21040 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after eaith and Mental Hygiene. 1 ∏ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No þ Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph (unk) Ganzzimiller Virginia (unk) Yoos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra 318 Laburnum Road, Edgewood, Maryland 21040 James Venker / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, Pages 1 20a. Method of Disposition 11-26te 07 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State First United Evangelical Luth. Cem. Dundalk, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Vascular Accident **Physician** Cerebral /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Fibrillation 24a. Was an performed? Yes 2 No Diabetes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 10 30\_Name and address of person who completed cause of death (Item 23a) (Type, Print) Mesapoake Dr. Bel. 500 U Patricia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For Amend Item 25 Registrar	per me, g8	73,11/2070	7dhb 23a tificate of	Death		a. No.	37930
	Physici	an	Decedent's Name (First, Middle, Last	)				Date of Death     Month	Day Year	3. Time of Death
	/Media			entz				November		7:52 A M
F	Examin	ıer	4a. Facility Name (If not institution, give				Location of Death		4c. County of Death	
			Shady Grove Adven			Rockvi			Montgomer	
	Funeral Director		195-03-3644	x 7. Age □M 2∭2F	91 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp Cour 1916 New	place (State or Foreign htry) York
	ehow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation			1	0d. Inside City Limits
	Mar	tor	Maryland Montgome	ry	Gaithersh	ourg				1 X Yes 2 □ No
	n the	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cour	ntry?
	th wil	alD	507 Russell Avenu	e #312		2087	7		United S	States
21215-0036	be filed within 72 hours after death with the Maryland atal Hygiene.  dother then "natural", or itema 23a or 28a-f ehow event, the Madical Examinar must be notilled at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Dates:	0	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
5-0	72 h	Completed	15. Decedent's Edi (Specify only highest grad		16a. Deced	lent's Usual Occup kind of work done	ation during most of work ()	ing 16	6b. Kind of Business/In	dustry
21	ithin	mpi	Elementary/Secondary (0-12)	Coltege (1-4or 5	+)		)		0 11-	
	2 should be filed within and Mental Hygiene. ie marked other then aumatic event, the Ma		47 5 4 1 No. (5: 4 45 (4) ( a)	22	нс	memaker		(5)	Own Home	
Maryland	be fill d ot	Be	17. Father's Name (First, Middle, Last)	hmoole Tw				e (First, Middle, Ma		
3	should be ind Mental   marked o	ဥ	John Francis Sc						Lundquist	
ā			19a. Informant's Name/Relationship (T						City or Town, State, Zip	Code)
	ges 1 end 3 of Health if item 27 or other tr		Victoria L. Wood/	Daughter	5306 20b. Place of Dispo			thesda, 1		20814
0	@ ° = 5		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ I	Removal from State	cemetery, cren	natory or other plac		er 11,	oc. Location - City or To	own, State
Ë			4 ☐ Donation 5 ☐ Other (Specify,		Montgomery		20		ethesda, Ma	
Baltimore,	permit. Pag Depertment Important: any injury o		21. Signature of Funeral Service Licens	reglu	M01173 Ro	Name and Address bert A. Pu 57 Wiscons	mphrey Funer in Avenue,	al Home, E Bethesda,	Sethesda—Chevy Maryland 208	7 Chase, Inc. 814
68760,	icate be executed /Medical bhysician and street sthe burial-transit	edical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of might) that intitated events resulting in death) Last	a. Cerebi Due to (or as a Due to (or as a cerebia)	ral Hemmorh a consequence of): a consequence of): a consequence of):	age		or inspiratory arrest		Approximate Interval Between Onset and Death Days
P.O. Box 68	The law requires that the death certificate be executed its hes been signed by the attending physician and bege 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
	w requires that been signed be should be det		Part II. Other significant conditions co	ntributing to death bu	it not resulting in the un	nderlying cause give	en in Part I.		cco use contribute to the	ne cause of death? pably 4 XIUnknown
of Vital Records,		Completed by						24a. Was an autopsy performe	prior to co death?	psy findings available mpletion of cause of 2 \square No
Vite	Physician: Th this certificete ral director, peç	Be	25. Was case referred to medical examiner?	Hospital:		1		h (Check only one)		
5	hys this al di	၉	138 163 270140		nt 2 ER/Outpatien		4   Nursing no		ce 6 □Other (Specif	y)
	ath. r: After ne funer	Certification:	27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time of Yea <i>r)</i> Injury	28c. Injun Worl M 1 []	y at <br Yes 2 □ No	28d. Describe how	injury occurred	
Division	if or Attendiater death. Director: A in by the fu	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At home, farm, str . (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Medical C	29a. Certifier (Check only one)  1 ☐ Certifying Phy 2 ☐ Medical Exam	sician: To the best of ner: On the basis of and manner sta	examination and/or inv	n occurred at the time vestigation, in my of	ne, date and place, pinion, death occuri	and due to the cau red at the time, date	se(s) and manner as s e and place, and due to	tated. o the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Month,	Day, Year)
1			Ulan Te i	hids -	Do	6	5189	I	November 8,	2007
(	50)		30. Name and address of person no Meenakshi G. And			•	er Drive.	Rockvil1	le, Marylan	ıd 20850
×.	Sta Registr		31. Date filed (Month, Day, Year) NOV 2, 0, 2007	Ann Dogistes	r's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 8874 12-6-07 vt. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) J. Wells 2. Date of Death Antoine / **Physician** Vovember /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL Greneral 1 aryland timore yrs. last birthdav If Under 24 Hrs. 5. Social Security Number 8. Date of Birth **Funeral** Months 1**☑**M 2□F Min 215-70-710 Usual Residence of Decedent Director State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show IV 1 Nes 2 No a Maryland Director nmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American India Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>^</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use refired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natu any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last Be Pages 1 and 2 should be 1 nent of Health and Mental ဂ 19a, Informant's Name/Relationship (Type. Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State Woodlawn, Hark ٥ 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of 21. Signature of Funeral Service Licensee yoseph MD 21216 North Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one are on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a conscille (e of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 1 ☐ Yes 2 ☐ No 9□Unknown 9 Hinknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be irector, page 2 s autopsy perform To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manno of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tes within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of ce

30. Name and address of

person who completed cause of death (Item 23a) (Type, Print)

90 32. Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year) 07

			State of Maryland / Department of Certificate o		ental Hygie	ne 2007	37932
	_		Registrar  1. Decedent's Name (First, Middle, Last)	n Dealli	Reg. 2. Date of Death	No.	3. Time of Death
	Physicia	an			Month	Day Year	
	/Medic		Benjamin Thomas Williams, Sr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town	n, or Location of Death	Nov. 23	, 2007 4c. County of Deat	1
	Examin	er	802 Old Fallston Road Falls			Harford	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ear If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
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	~ 1 ~		Usual Residence of Decedent		02.10.1	742 1 111	
	irylar ihow	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 No
1	Ba-f s	cto	MD   Harford   Fallston				
3	or 2	Director	10e. Street and Number 10f. Zip Code		"	Citizen of What Co	untry?
:	death with the Maryland ms 23a or 28a-f show r must be notified at	ra	802 Old Fallston Road 210			U.S.A. 14. Race - Ame	ricen Indian
	er de Item: ner n	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married	of Hispanic Origin? (Spe Cuban, Mexican, Puerto F	City Yes of No- Rican, etc.)	Black, White	
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ם פ	al Hy lothe	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	, ,		
ylan	Mental Mental arked o	2	Fredrick Thomas Williams	Josephi	ne Flet	cher	
ar a	2 short and Is made and and and and and and and and and and		19a. Informant's Name/Relationship (Type. Print)  Williams, Jr/son  19b. Mailing Address (Stre			-	
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0	Pages 1 nent of H ant: If Ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Sermation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other)	1		•	
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ng ng	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			ative 8717			eral Balto
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of				Approximate
Ļ			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	1 Post of the second of the se	roopiiatory arroof	1	Interval Between Onset and Death
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۽ م	certific nding p	Mec	IF FEMALE:				
ž Ros	death or e attend ed for us	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pt pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregna			23d. Date of del Month	ivery Day Year
	ne de the a hed f	hysician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify 9 ☐ Unknown	/}			
7	that the	Δ.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds,	w requires that the death certific been signed by the attending p should be detached for use as	d by	Charge Obstacting Value V	Siece	1 ☐ Yes	2 No 3 P	obably 4 Unknown
Ō	v req been shoul	ete			24a. Was an	24h Ware at	itopsy findings available
ě	ne law has b ge 2 st	Completed			autopsy performe	prior to	completion of cause of
VITAI	n: II fficate or, pa		25. Was case referred to medical	OC Place of Death		No 1 □ Yes	<b>Q</b> □ No
5	sicia s certi lirecto	o Be	examiner?	Other:	*	ce 6 □Other (Spe	oifu)
o i	g Fny er this eral d	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. I		28d. Describe how		Cny)
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SIN :	Arrest ar deg recto by th	ific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, offi building, etc. (Specify)	ice 2	28f. Location (Stre	et and Number or R	ural Route Number,
5	ral or ra after at DII	Certification:	bunding, etc. (aposity)			Jacop	
	Hospi 4 hou Funer ely fill	edical	29a. Certifier  (Check only Medical Examiner: On the basis of examination and/or investigation, in n	ne time, date and place, a my opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	s stated. e to the cause(s)
	I of the hospital of Attending Prlysician: The lay within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medi	one) And manner stated.  29b. Signature and title of certifier 29c. Lice	cense number	294	. Date signed (Mont	h. Dav. Year)
1	- × - 8			/			
/	(X)		3b. Name and address of person who completed cause of death (Item 23a) (Type, Print)	39022	10	Vember 6	7 (07)
1			1308 Grane C. Sheel 1308 Grane C. L. Way F	dianel	16177 7	(04x	247027
B	∘ Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1			
	Registr	ar	NOV 2 8 2007 January 25 April 2019				

State Registrar

NOV 2 8

2007

Concentration Name (Price Modes, Late)   Security (Control Name (Price Modes), Late)   Security (Control Name (P				For State Registrar	State of Ma	aryland / I		artment rtificate			ind Me		giene Reg. No	000-	37	1934
4. Scenario Procedo Description of Description of Technology (Control Procedo) (Cont			-		ms							Month	Da			
\$ 5000 Security Number   \$ 5000 Security Numbe	)				,	er					f Death			. County of De	ath	<u>J am</u>
The State of the Country of the Coun				456-14-4104 <sup>1</sup>	M 2 7. Ag			If Under	1 Year	If Under 2	24 Hrs. Min.	8. Date of Birl (Month, Da	y, Year	9. B	irthplace (Sta	te or Foreign
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Elementary/Sepondary (p-12)   College (1-for 5-)   Homemaker   H	920	urs after deat ai", or Items ' Examiner mu	by	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	Ever in U.S. No					jin? (Spec , Puerto P	cify Yes or No Rican, etc.)		Black, Wh	ite, etc.	9
A   Donation   S   Other (Specin)   Southern   Memorial   Park   11/28/707   San Antonio, TX	1215-0	vithin 72 ho ne. han "natur e Medical I	mpleted	(Specify only highest grade	completed)	5+)	(Give life. l	kind of wor DO NOT us	k done d e retired)	ution uring most	of workin	g		Kind of Busines		
A   Donation   S   Other (Specin)   Southern   Memorial   Park   11/28/707   San Antonio, TX	land 2	uld be filed v Aental Hygie rked other i tic event, th	Be				поше	шакег					Maide			
A   Donation   S   Other (Specin)   Southern   Memorial   Park   11/28/707   San Antonio, TX		and 2 sho saith and N n 27 is ma er trauma														
Physician Medical Examiner    Physician Medical Examiner   933 Gist Ave. silver Spring. MD 20910   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock, or heart failure. List only one cause on each line.   Approximate shock or line.	limore	Pages 1 treent of He tant: If Item		XXBurial 2 □Cremation 3 □ Re	emoval from State	1	ern	Memor	ial	Park	11/	28/07	Sar	n Anton	io, TX	
Physician / Medical Examiner    Physician / Medical Examiner   Physician / Medical Examiner   Physician / Medical Examiner   Physician / Medical Examiner   Physician / Medical Examiner   Physician / Medical Examiner   Physician / Medical Examiner   Physician / Medical Examiner   Physician / Medical Examiner   Physician / Physici	Ball	permit Depar Impor any In		1 Styler & Xol	man	n	- c	33 Gi	st A	ve. S	Silve	r Spri	ng.		10	
Due to (or as a consequence of):    Security of the content of the		/Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cause on each li	GUST	71	T	40	ART	F	9140	IR(		19 et a	Toxba
FEMALE:   23d. Date of delivery	7,092	e be executed rician and e burial-transit	cal Examiner	that initiated events				1AZ	-	INF	AR	CT(	Øλ	/	184	10nbh
The composition of cause of death   The completion	Box 6	ne death certifi the attending p hed for use as	ysician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1□Live birth 4□Pregnant a	2 Fetal deat										Year
24a. Was an autopsy performed?   1   Yes 2   No   25b. Was case referred to medical examiner?   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case referred to medical examiner.   25b. Was case re		quires that to signed by all be detact	d by Ph	Part II. Other significant conditions con	tributing to death b	ut not resulting i	in the u	nderlying ca	use give	n in Part I.						
The property of the part of th	I Reco	The law ate has b page 2 sh	Complete				-					auto; perfo	osy rmed?	death	?	igs available of cause of
Solution   Signature   Signa	r Vita	nysician: iis certific director,	Be	examiner?	ospital: 1 ☐ Inpatie	ent 2 ER/O	utpatien	it 3 DO	A Othe			(Check only o	ne)			
5 DAVID A. GOUNAY. MD. 1456 Mereanbile Ln. LARGO, MD. 2077	sion o	tending Present.  or: After the funeral		1 Pending 2 Accident 5 Pending investigation	(Month, Da	y Year)	Injury	М	1 🗆 1	at ?	2					
5 DAVID A. GOUNAY. MD. 1456 Mereanbile Ln. LARGO, MD. 2077	Divi	oital or Att urs after de vrai Direct	Certific	4 ☐ Homicide determined								City or To	vn, Stat	te)		lumber,
5 DAVID A. GOUNAY. MD. 1456 Mereanbile Ln. LARGO, MD. 2077		the Hosp thin 24 hor the Fune	Medical	one) Medical Examin	er: On the basis of and manner st	if examination a ated.	nd/or in	vestigation,	in my or	oinion, dea	th occurre	ed at the time,	date ar	nd place, and d	ue to the caus	
		F ₹ 6 8		255. Signature and the of Certifier	tora	tro.		290	1) 2	281	95		<b>√</b> 0	V 2	b, 20	77
		5		30 Name and address of person who con G ( 31. Date filed (Month, Day, Year)			74	50 M	er	eanl	rile	Ln	. L	ARGO	, MD.	20770

Registrar
DHMH 17 Rev 1/2001

		·		State of Marylar esm 23a,27 pc	nd / Depa er de	artment 1873 Hilcate	of He 11/2 10/E	alth a 8/070 realth				007		935
	Physici /Medic		Decedent's Name (First, Middle, Last)     Stephanie Waldero	n					N	Date of Deat Month ovembe	r 10,	Year 2007	3. Time o	
	Examir Funeral	er	4a. Fecility Name (If not institution, give s  4908 East West Hi  5. Social Security Number 6. Sex	ghway 7. Age (In yrs.	* * *	If Under 1	rerda		24 Hrs.   a	Date of Birth (Month, Day,	Pri	9. Birth	n eorge † s nplace (State untry)	
D	Director	tor	Usual Residence of Decedent  10a. State  10b. County	10c. Ci	Yrs. ty, Town or Lo Riverda				Ma	ar 2/,	1964		10d. Inside 0	
h with the	23a or 286 at be not	ai Director	10e. Street and Number 4908 East West Hig	ghway		10f. Zip (	Code	2073	37	1	•	of What Co	untry?	
d 21215-0036 filed within 72 hours after death with the Maryland	and Mental Hygiene. Ie marked other then "naturel", or Iteme 23a or 28e-f ehow aumatic event, tra Medical Examinar must be notified at	by Funeral	11. Marital Status unk  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decede		panic Orig , Mexican, Specify:	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)		Race - Ame Black, White ecify: b1	e, etc.	
71215-0036 within 72 hours af	then "natur the Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) unk U:	cation e <i>completed)</i> College (1-4or 5+) nk	(Give	dent's Usual kind of work DO NOT use	done du		of working	unk	16b. Kind	of Business/	Industry	unk
<b>⊆</b> 8	d Mental Hygi narked other natic event, I	To Be Co	17. Father's Name (First, Middle, Last)							irst, Middle, I				unk unk
ore, Mar as 1 end 2 st	Health em 27 ther tr		19a. Informant's Name/Relationship (Ty Ofcr Somerville/P) 20a. Method of Disposition	G Police Dept		sition (Nam	e of	1	r or Rural R	oute Number		ion - City or		
Baltimor permit. Peges	Department Importent: If any injury or page.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Services	in state	r St	2. Name and Cate A	Address	of Facility		55 W.	Balti	imore	Street	
1	nysician Medical		23a. Part. Enter the disease, or compleshoot or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the dea ne cause on each line.  A CULO  Due to (or as a consec	th. Do not en	altimo ter the mode	of dying		cardiac or re	espiratory arri	est,		Approxima Interval Be Onset and	etween Death
	physician and institution with the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect  Cigarett  Due to (or as a consect  Due to (or as a consect  d.	quence of): e Smok	ing							Years	3
I HECOLDS, P.O. BOX 68 /60, The law requires that the death certificate be executed	y the attanding phiched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregn 1	aldeath 3	□Ectopic pre					23d	. Date of del Month	ivery Day	Year
rds, P quires that	been signed by the s should be detached	ρ	Part II. Other significant conditions con	ntributing to death but not re thromboSIS	sulting in the u	inderlying ca	use give	n in Part I.			bacco use es 2 🗆 N		the cause of obably 4	death?
al Keco : The lawre	cate has bee , page 2 sho	Completed	Sheep aprice	ive Lung dris	serve					24a. Was a autops perform	y	A4b. Were au prior to death?	itopsy finding completion of	s available cause of
DIVISION OF VITAL MECOFUS, Lor Attending Physician: The law requires t	within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		C. Injury Work	r: 4□Nui	rsing Home	5 Reside	ence 67		city) Syru	phome
DIVIS	within 24 hours after death  To the Funerel Director: A  completely filled in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Spec	ify)					Location (S City or Town	n, State)			mber,
To the Hospital	in 24 hou the Fune opletely fil	ledical	(Check only 2   Medical Exami	ner: On the basis of examin and manner stated.	nwledge, deat ation and/or in	ivestigation,	in my op	inion, deat	d plane, and th occurred	at the time, d	ate and pla	ace, and due	to the cause	
٥	To T	×	29b. Signature and title of certifier	MO			License		3411	2			h, Day, Year)	
			· ·	llow Fox L	n #	Print)		Box	nie	MI	>	2071	5	
le.	Sta Regist		NOV 2 8 200	Registrar's Sign	ature	ate I								

			riease i y								Legible.		
		-	_ State	tate of Mai	-		cate of	lealth and M			0007	^ •	7006
			Registrar  1. Decedent's Name (First, Middle, Last)			er time	Jale UI	Dealli	2. Date of De	Reg. No.	2007	3 Tim	e of Death
	Physicia /Medic	an	VIRGINIA	LAUR	A W	ATS	SOM		Month	Day	2/ Year	7 19	: 24 P M
	Examin		4a. Facility Name (If not institution, give stre	et and number)		1	-	r Location of Death		4c.	County of Dear		
-36	<b>装 </b>		3001 SOUTH HA	NOVER		-		MORE If Under 24 Hrs.	9 Doto of Bir		0.8	N/A	A au Canalan
# <sup>5</sup>	Funeral		5. Social Security Number 6. Sex 1 ☐ M	2□ <b>y</b> F 7. Age	(In yrs. last birtho	Mor	nths Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)	Co	ountry)	ate or Foreign
	Director	8	215-30-7073 Usual Residence of Decedent		72				Oct	29, 19	35	Maryla	anu
	yland how at		10a. State 10b. County		10c. City, Town o	r Location	1						e City Limits
	e Mar ia-f sl	ctor	Maryland N/A	\ <u> </u>				Baltimore				1 📙	Kes 2 □ No
	or 28	Director	10e. Street and Number			10	f. Zip Code			10g. Citi	zen of What Co		
	ath w s 23a nust b	ra	2608 Hollins Ferry Road			40. 10/2 2 5	D d	21230	if - V/ N/-		U. 14. Race - Ame	S.A.	2
	items	Funeral	11. Warran Status	Was Decedent Ev Armed Forces?	ver in U.S.	If Yes	, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	)-	Black, Whit		1,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	वि	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ X If Yes, Give X Year or Dates:		1 🗆 Y	es 2□ <b>1</b> Xo	Specify:			Specify:	Black	<b>.</b>
5-0	72 h 'natu dical	etec	15. Decedent's Educati (Specify only highest grade co	on ompleted)	1 (0	Give kind	Usual Occup of work done	during most of work	ing	16b. Ki	nd of Business	/Industry	
12	within ane. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	re. DO N	OT use retire	<sub>ण</sub> teria Worker			Baltimo	re Scho	ools
d 2	filed Hygir ther	ပ္တို	17. Father's Name (First, Middle, Last)		1			18. Mother's Nam	e (First, Middle	, Maiden	Surname)		
lan	ld be ental ked o	To Be	Harrison	James						Marie	James		
ary	2 should be n and Mental Is marked or raumatic ev	-	19a. Informant's Name/Relationship (Type.	Print)	19b. N	Mailing Ad	dress (Street	and Number or Rui	al Route Numb	er, City o	r Town, State,	Zip Code)	
	and 2 ealth a 27 Is er trat		Donald Watson, Jr.			260	8 Hollins	Ferry Road B	altimore, M	larylan	d 21230		
ore	of He of He fitem		20a. Method of Disposition 1 □ Rurial 2 □ Cremation 3 □ Rem	oval from State	20b. Place of D cemetery,	isposition cremator	(Name of ry or other pla	ce)	Date	20c. Lo	ocation - City or		
Ĕ	Pages ment of lant: If its	١.	4 □ Donation 5 □ Other (Specify)		Crow	-		Cemetery	11/21/07	7	Crown	sville, M	ld.
Baltimore,	permit. Departr Importa any Inj		21. Signature of Funeral Daniel Livense	8	SA	22. Nar	ne and Addre	Brothers Fun	eral Servic	e, P. A	<u>.</u>		
P	6,		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one	tions that caused	ne death. Do no	t enter the	1300 e mode of dyi	Eutaw Place I	or respiratory a	rrest,	21/	Approx	imate I Between
	Physician		Immediate Cause (Final disease or condition	ACUTE	RENA	14 7	FAILU	RE.					Between and Death
	/Medical		resulting in death)	D 1 (1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					- 0				
	Examiner		Securation list conditions b	MRSA	ANDE	NTE	ROCOC	CAL SE	PLIS			14:	ZYAO
	p tis	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	PELVIO	consequence of		OMA					7 1	ZKAC
72	ecute and	Examin	that initiated events resulting in death) Last		consequence of		Oppira					, ~	
760,	icate be executed physician and s the burial-transit	calE	d		12ATO		FAIL	LURE.				28	ZEAG
9	tificat ig phy as th												
Вох	death certifical e attending phy d for use as th	an/N	230. was decedent pregnant	If yes, outcome p		3 □Ecto	opic pregnanc	·y			23d. Date of de Month	elivery Day	Year
0	at the dea by the at tached fo	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death	5 ☐ Oth	er (specify) _				WOTH	Day	Teal
Δ.	that the led by th detache		Part II Other significant conditions contri	buting to death bu	t not resulting in t	he underl	vina cause ai	ven in Part I.	23e. Did	tobacco	use contribute t	to the cause	e of death?
ds,	e all	d b	ALZHEIMER	S DE	MEN.	TIA			1 🗆	Yes 2	□No 3□F	robably	4. Unknown
Records,	> 0 0	Completed	COAGULOPAT	H J.					24a. Was	an.	24h Were s	utoney find	ings available
Re	(C) (C)	dm							auto perf	opsy ormed?	prior to death?	completion	of cause of
ta			25. Was case referred to medical					26. Place of Dea	1 Yes	2 No	1∐Ye	s 2□No	
or Vital	Physician: r this certific ral director,	o Be	examiner?	pital:	nt 2 ☐ ER/Outp	atient 3	DOA Ot	hor		,	6 □Other (Sp	ecify)	
	g Physter this	Ë	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Tii	ne of ury	28c. Inju		28d. Describe				
ior	Attending F r death. ector: After by the funer	atio	2 Accident investigation	(		.,		]Yes 2□No					
Division	or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju building, etc		n, street, f	factory, office		28f. Location City or To		nd Number or F e)	Rural Route	Number,
	pital c urs af eral D		One Contiller ATTOMACE IN THE	lan. To the best -	f my knowlede -	dooth ac-	urrad at the t	ima data	and due to the		) and mass.	on otesta d	
	s Hospital or Attend 24 hours after death. 5 Funeral Director: A etely filled in by the fi	Medical	29a. Certifier  (Check only one)  1 Certifying Physic  2 Medical Examine		examination and								use(s)
	To the Hosi within 24 ho To the Function	Mec	29b. Signature and title of certifier					se number		29d. Da	ite signed (Mor	nth, Day, Ye	ear)
<b>)</b>	<b>⊢</b> ≶ <b>⊢</b> ô		Dyge Ih	ecgne,	G. M	$CI \cdot$	RE-	0002		NO	VEMBE	ER 2	1 200-
•		1	7 9	7									

3

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONITE THEAGWARA
3001 SOUTH HANOVER STREET, BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year) NOV 2 8 2007

32. Registrar's Signature

21225

07-08908		Please Typ	e or Prin ate of Mai	ryland	/ Depart	ment of	Health	and	Menta	l Hygier	ne		20	0.7	3793
Henry Williams	1-	For State	ite oi iviai	i ylalla	Certi	ficate of	Death					. No			
Physician	_	gistrar Decedent's Name (First, Middle	e,Last)							2. Dat	te of Death	Day Y	rear	3. Time o	
Mediani Examine		Henry Willia									vember	Day 17, 2007	ty of Death		
1	4:	a. Facility Name (if not institution	1, give street ar	nd number)	)	4	b. City, Too Baltim		ocation of L	Jeath			/ A		1
		113 N. Fulton Ave					If Under		If Under 2	24Hrs. 8. D	ate of Birtl	n(MM/DD/YY	YY) 9. Birt	hplace (S	State or
Funeral	5	Social Security Number	6. Sex		ge (In yrs. las		Months		Hours	A diam			Foreig	gn untry)	Md
Director	2	16-84-2241	1 XM 2	F	44	Yrs				4	/4/1	903			
	Ū	sual Residence of Decedent			Inc City T	Town or Locati	on							10d. Ins	ide City Limits
w any	1	0a. State 10b. County												1 XY	Yes 2 No
land f sho	ğĹ	Md. N/A			Ва	altimo	10f. Zip (	Code			10	og. Citizen of	What Cou	ntry?	
Mary Mary	Director	0e. Street and Number		Arron	1110		212	993				USA			
death with the Maryland or items 23a or 28a-f show must be notified at once.		113 North F	11 LOII	A V C II	nt Ever in U.S	3. 13. Wa	os Deceden	t of Hisp	anic Origin	n? (Specify	Yes or No	- 14. R	Race - Amer	ican India	an, Black,
th will		Marital Status     XNever Married 2	farried Arr	ned Forces		lf \	es, specify	Cuban,	Mexican, I	Puerto Ricar	n, etc.)	l v	Vhite, etc.		1
er dea			vorced If Yes, G	ive Year	ZA NO		Yes 2		specify:			Spec		lack	
irs aft ural"	ᆰ	15. Decedent's Education (Spe			ompleted)	16a. Deceder	nt's Usual C	Occupation	on (Give ki	nd of work ouse retired)	done	16b. Kind o	of Business	/Industry	
2 hou	뜷	Elementary/Secondary (0-12)		lege (1-4 o					501101			D	.+. (	Tomp	ony
136 thin 7 ne.	Completed by	12				Cus	todia	an	10 1 4 a 4 b a wh	Nomo /Fire	et Middle	Priva Maiden Surn		Joinb	any
5-0036 iled within 7. Hygiene. d other than		17. Father's Name (First, Middle						- 1'				iams	,		
2121 ould be fil Mental b marked ic event,	8	Henry Willi	ams	nt )		19h Mailir	na Address	(Stree	t and Num	ber or Rural	Route Nu	mber, City or	Town, Sta	te, Zip Co	ode)
hould mit Multiple is ma	2	19a. Informant's Name/Relation		in )		3/38	Car	riad	re H	i11 C	Cir.F	?anda.ˈ	11st	own.	Md
MD and 2 sho salth and em 27 is raumati	-	Shirley Wil	TTams		20b. I	Diana of Diana	cition (Nan	ne of cer	neterv. I	Da	ate	20c. Loca	ition - City o	or Town, S	State
Ore, of He	-1	1 XBurial 2 XCrematic	on 3 Rem	noval from	State	rematory or Creater Cally	natory	Com		11/24	1/200	7 Ba	ltim	ore,	Md.
tim trent:	,	4 Donation 5 Other 3	Specify:	- 1	IM C	22.	Name and	Address	of Facility	ore I	Tunei	cal S	ervi	ce.	PA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	- 4	NOD111	10	10	nst		1200	E-11-	+ 0.337	D I a c c	2 K2	1 T. 1 MO.	re.w	u . 2	1141
Physician	-	23a. Part I. Enter the disease,	or complication	s that caus	ed the death	. Do not enter	the mode	of dying,	such as c	ardiac or res	spiratory a	rrest, shock,	or heart	/ upp	ween Onset and
* 'edical	ı	failure. List only one caus	e on each line.	hemic	bowel d	isease c	omplic	ated	by que	etiapin	e into	<u>xicatio</u>	n		Death
aminer.		Immediate Cause (Final diseas or condition resulting in death)	Due to	(or as a co	onsequence o	of):								1	ì
		Sequentially list conditions,	b		nsequênni :	·A:								_	
	iner	if any, leading to minediate cause. Enter Underlying Cause	se .	(or as a co	N. Section 1995									4—	
W	Examiner	(Disease or injury that initiated events resulting in death) Las	t Due to	(or as a co	onsequence	of):									
executed ian and ial - transit	Ē		d		POS DIT	27 282-	-f ner	ME. o8	374. 1	2/13/07	TT			1	
e exectan a	dical	X UNPENDED	X AME	NDED #	20a.b.p	,27,28a erFH,087	v3,11/2	8/07	WS _			23d F	Date of deliv	verv	
Box 68760, e death certificate be the attending physici ed for use as the buri	sician/Med	IF FEMALE: 23b. Was decedent pregnant in	230	Live birt	tcome of pre	gnancy	Fetal death			ic pregnanc			onth	Day	Year
(68) certifi ending use as	ian	past 12 months?	4		nt at time of c	-	Other (Sp								
SOX death se atte	ysic	1 Yes 2 No 9	0	Unknow							l ogo Die	d tobacco us	e contribut	e to the ca	ause of death?
O. B. that the detached detached	, Phy	Part II. Other significant con	ditions contr	ibuting to d	death but not	resulting in th	ie underlyir	ng cause	given in F	'art I.					4 Unknown
, P.O. ires that the signed by t	d b	End stage renal	disease								24a. W		24b. Wer	e autopsy	findings available
ords, w requir	lete										au	topsy erformed?	prior deat	to comple	etion of cause of
SCOI re law te has ge 2 sl	Completed											s 2 No	1 🗸	Yes	2 No
/ital Rec ysician: The I his certificate director, page		25. Was case referred to med	lical					26.Pla		h (Check on			2 2	715 Cae	
<b>/ita</b> /sicia his cer direct	B B	examiner?	Hospit	al: 1 In	patient 2	ER/Outpat		DOA	Other <sub>4</sub>		Home 5	he how injury	ce 6 🗸 C	Jiner: Sce	nte
of \ing Phi	5	27 Manner of Death	2	28a. Date of (Month,	of Injury Day,Year)	28b. Time	of Injury		ijury at Wo	No.		De now injury	, 0000		
On tendir eath.	iĝ	1 Natural 5 F	Pending nvestigation	FNd 11	/17/200	7 Fnd 4:	00 pm	1			unk	n (Street an	d Number	or Rural P	Route Number, City
Division of Npital or Attending Phours after death.		3 Suicide 6 X	Could not be			home, farm,	street, facto	ory, office	e building,	etc.	or Tow 113 N.	n, State)			more, MD
Divis  Divis  1 Hospital or A 24 hours after Funeral Dire	Certification:	4 Homicide	determined		residen			the time	date and	nless and s	due to the	cause(s) and	manner as	stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physici from pleave frilled in by the funeral director, page 2 should be detached for use as the burit			g Physician: 1	To the best the basis o	t of my knowl of examination	edge, death c n and/or inves	tigation, in	my opin	ion, death	occurred at	the time, o	late and plac	e, and due	to the ca	use(s)
To the 110 within 24 k	Medical	29b. Signature and title of ce	anu	manner st	ated.				ense numb			29d. D	ate signed	(Month,	Day, Year)
	2	290. Signature and title of ce	//	n)	<b>\</b>			0.0	C.M.E.			Nove	ember 18	3, 2007	
λ.		30. Name and address of pe	anell	plated caus	se of death (II	tem 23a)									
pxperd.		30. Name and address of pe Melissa Brassell, N		stant Me	dical Exar	miner 1	I1 Penn	Street	, Baltim	ore, MD 2	21201				
DK1 1	3,-1			67	gistrar's Sign	- 17	SALL!								
Regi	Stat istra		8 2007	1	was de	1	202000								

DHMH 17 Rev 1/2001 OCME 2006

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

NOVEMBER 23, Year 2007

4c. County of Death

3728 HUDSON STREET 2nd FLOOR BALTIMORE N/A	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 219-66-6417 52 Yrs. 52 Yrs. 52 Yrs. 3 Social Security Number 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 Country PENNSY 52 Yrs. 52 Yrs. 52 Yrs. 52 Yrs. 52 Yrs. 52 Yrs. 52 Yrs. 52 Yrs. 52 Yrs. 52 Yrs. 52 Yrs. 54 Yrs. 55 Yrs	
Usual Residence of Decedent	TUANTE
	le City Limits
N/A BALTIMORE	Yes 2□No
MD N/A BALTIMORE  10e. Street and Number  3728 HUDSON STREET 2nd FLOOR  11. Marital Status  1 Never Married  12. Was Decedent Ever in U.S. Armed Forces?  11. Never Married  12. Was Decedent of Hispanic Origin? (Specify Yes or No-life Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian Black, White, etc.	
3728 HUDSON STREET 2nd FLOOR 21224 U.S.A.	
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	n,
Specify: Specify: Specify: WHITE	
15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of working life. DO NOT use retired)	
To be a first transport of the first transpor	ENTER
TO COSTODIAN CONVENTION CENTROL	
WALTER CHASE FITZPATRICK DAISY ELIZABETH DONALDSO	ON
The state of the s	2122/
KIM WILSON/ HUSBAND 3728 HUDSON ST., 2nd FLOOR, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	
1文 Burial 2	ARYLANI
	21231
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately a such as cardiac or respiratory arrest, interval.	imate I Between and Death
Physician disease or condition disease or condition a. RESPICTO M. MILE	and Death
/Medical resulting in death)  Due to (or as a consequence of):  Examiner	
Sequentially list continuous, if any, leading to immediate Due to (or as a consequence of):	
Due to (or as a consequence of):  cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
resulting in death) Last Due to (or as a consequence of):	
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury th	
So the past 12 mogaths?  IF FEMALE: 23b. Was decedent pregnant in the past 12 mogaths?  23c. If yes, outcome pf pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy 1   Diverging the past 12 mogaths?	
23d. Date of delivery    23d. Date of delivery	Year
O the point of the	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of the ca	
Sport of the state	4 □Unknown
24a. Was an autopsy finding prior to completion death?  1   Yes 2   No 1   Yes 2   Yes 3   No 1   Yes 3   Yes	ngs available of cause of
24a. Was an autopsy performed?   24b. Were autopsy finding prior to completion death?   1   Yes   1   No   1   Yes   2   No   No   1   Yes   2   No   No   1   Yes   2   No   No   1   Yes   2   No   No   No   No   No   No   No	
The state of Death (Check only one)    Control of the state of Death (Check only one)   Check only one)	
The splicial of Indian in	
27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  M 1 Yes 2 No  28d. Describe how injury occurred	
28d. Describe how injury occurred    Second   Part	Number,
	uon(o)
29a. Certifier   129a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)   129a   1	
29c. License number 29d. Date signed (Month, Day, Yea	ar)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last)

ANN

4a. Facility Name (If not institution, give street and number)

WILSON

RUTH

**Physician** 

/Medical

Examiner

BALTIMORE, MARYLAND ERAL HOME TIMORE, MD. 21231 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ √16 No e 6 □Other (Specify) njury occurred t and Number or Rural Route Number, tate) se(s) and manner as stated.
a and place, and due to the cause(s) Date signed (Month, Day, Year) BACKMORD MO

37938

9:06 ph

State Registrar

Sugar.

51.

32! Registrar's Signature

		,	1- For State of Mar State Alegistrar		artment of H rtificate of L			en 2007	37939
	hysici		1. Decedent's Name <i>(First, Middle, Last)</i> Henry F. Wisniewski				2. Date of Death Month Nov	Day Year 24, 2007	3. Time of Death  2:28 p
	/Medic xamin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1100	4c. County of Dea	1 2.20p
_	, and		Heritage Nursing Center		Dunda	a1k			ore Co.
Fu	neral			In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	ector		217-03-9504 <sup>¹◙™ 2□F</sup>	92 Yrs.	Months Days	Hours Min.	(Month, Day, 19 – 21 –	1915 Mar	yland
and	š		Usual Residence of Decedent           10a. State         10b. County         1	0c. City, Town or Lo	cation				10d. Inside City Limits
Maryl	ied a	ō	MD N/A	D 1					1⊈Yes 2□No
the the	notif	Director	10e. Street and Number	Balti	nore 10f. Zip Code		10	g. Citizen of What Co	ountry?
th wit	st be	alD	1344 Broening Highway		21224			USA	
dea	E III	Funeral	11. Marital Status  12. Was Decedent Ever Armed Forces?	er in U.S. 13.	Was Decedent of Hi I Yes, specify Cuba	spanic Origin? (Span	cify Yes or No-	14. Race - Ame	
at yiaitid Z I Z I 3-0030 should be filed within 72 hours after death with the Maryland and Mental Hyglene. The street Ather then "settings" or thome 320 at 200 ft show	o oner train fraum of rems 23a of 20a-1 snow event, the Medical Examiner must be notified at	by	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2💢 No	Specify:	riidaii, eid.	Black, White	
72 Po	dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation Jurina most of worki	na 1	6b. Kind of Business	Industry
within Sine.	Me Me	mpl	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired		,9		
should be filed within Mental Hygiene.	it.		8 N/A  17. Father's Name (First, Middle, Last)	Ste	eam Fitt	18. Mother's Name	(First Middle M	Union	
id be file ental Hy	o e ve	To Be	John Wisnieski			Sophia		,	
2 should be fand Mental H	nmat	٦	19a. Informant's Name/Relationship (Type. Print) Sist	or 19b. Mailin	ng Address (Street a	<b>_</b>		City or Town, State,	Zip Code)
and 2 sleath an	er tra		Johnnie Wisniewski- in L	aw 1344	Broenir	ng Hwv.	Baltimo	ore, MD	21224
es 1 a of Hee	t to		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place	e) [	ate 2	0c. Location - City or	Town, State
Pages ment of	uryo		4 Donation 5 Other (Specify)	Holy Ros				altimore	
partifications, waryta permit. Pages 1 and 2 should Department of Health and Men	any in		21. Signature of Funeral Service Licensee					ki Funer imore, M	al Home, PA D 21222
100			23a. Part1. Enter the disea , or complications that caused th shock, or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying	g, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
Physi			Immediate Cause (Final disease or condition	ocan,	BLAZ	INF	nezi	on	Onset and Death
/Med Exam	dical niner		resulting in death)  Due to (or as a continuous)						
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of:					
uted	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	81					
c, exec	rial-tra		resulting in death) Last  Due to (or as a c	onsequence of):					
ficate be ex	as the burial-transit	edical	d						
ertific	east	Appear	IF FEMALE:						
eath ce	for us	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf 1 □ Live birth 2   4 □ Pregnant at time	☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date of de Month	livery Day Year
the d	ched	hysician/N	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at tin 9 ☐ Unknown 9 ☐ Unknown	ne or death 5L	Other (specify)				ŕ
s that	e deta	by Pr	Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
equire	rector, page 2 should be detached for use						1 ☐ Yes	s 2 □ No 3 □ P	robably 4 hnknown
law re	2 sho	Completed					24a. Was an	24b. Were a	utopsy findings available
The The	by the funeral director, page	E					autopsy perform 1∐ Yes 2	ed?   death?	completion of cause of 2 □ No
ician Sertific	ector.	Be	25. Was case referred to medical examiner?		la	26. Place of Death	(Check only one	)	
Phys	al dir	은	1  Yes 2  No Hospital: 1  Inpatient  27. Manney of Death	2 ER/Outpatien		4 LIF Nursing Ho		nce 6 Other (Spe	cify)
ding P.	fune	tion	1 Natural 5 Pending (Month, Day Y	(ear) Injury	Work	rat :? /es 2 □ No	28d. Describe how	v Injury occurred	
Atten deat	y the	fica	3 Suicide 6 Could not be determined 28e. Place of injury	- At home, farm, stre			28f. Location (Stre	eet and Number or R	ural Route Number.
s afte	ni be	Certification:	4 ☐ Homicide determined building, etc. (	Specify)		V.	City or Town,	State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 Hours after death.	completely filled in	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of roughless of evand manner state.	xamination and/or inv	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the car ed at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
To th Withir	comp	Me	29b. Signature and title of certifier		29c. License		29	d. Date signed (Mon	th, Day, Year)
			) Atum	P	02	3130		11-24	-07
6			30. Name and address of person who completed cause of deat ## ATTO	h (Item 23a) (Type, I	Print) 39	27, AN	NAPOLI	s Korn	21227
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's						
R	egistr	ar	NOV 2 8 2007	A A A	made a				

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

MD, DME 1614 CHERCH VILLE AS BEL AIR Md 21015

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

BERNARD YUKNA

NOV 2 8 2007

31. Date filed (Month, Day, Year)

		Pleas	e Type or Pri					-		egible.	
		For State Registrar		iaryiano /		artment of H			Reg. No. 2	007	37941
Physi /Med		1. Decedent's Name (First, Middle, Walter Richar	•					2. Date of D Month	Day	2007	3. Time of Death 6: 45 A M
Exam	iner	4a. Facility Name (If not institution,  Levindale Geria				4b. City, Town, or Baltir		th	4c. C	ounty of Deat	th
Funera			3. Sex 7. A	ge (In yrs. last	birthday)	If Under 1 Year Months   Days	If Under 24 Hrs		rth av. Year)	9. Birt	hplace (State or Foreign
Directo	r	339–20–4437 Usual Residence of Decedent	1 <b>∑</b> M 2□F	78	Yrs.	- Dayo		02/14			yland
ryland how		10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
he Ma 8a-f s	ecto		timore	Coc	ckeys	ville			40 000		1 □Yes 2 No
3aor3	Ö	10e. Street and Number 10535 York Road				10f. Zip Code 2103	30			n of What Co d Stat	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ▼ Divorced	12. Was Decedent Armed Forces' d 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	?   <b>N</b> o		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No		Specify Yes or N to Rican, etc.)		. Race - Ame Black, White pecify: Wh	e, etc.
5-0 72 ho	eted	15. Decedent's (Specify only highest			(Give	lent's Usual Occup	during most of wo	orking	16b. Kind	of Business/	Industry
within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		00 NOT use retired <b>airman</b>	1)			Typewr	iter
Maryland 21215-0036 nd 2 should be filed within 72 hours aff the and Mental Hygiene. 27 is marked other than "natural"; or traumatic event, the Medical Examir traumatic event, the Medical Examir	Be C	17. Father's Name (First, Middle, Li	ast)					me (First, Middle	e, Maiden Si		
hould the Ment	2	John Zemroz	/Time Drint)		Ob Mailis	- Adduses (Ctreet		Wlagos		Ot-1-	7. 0. 4.)
Mal nd 2 sl alth an 27 is r		19a. Informant's Name/Relationshi Tasha Zemrus Gre				ntvieu Co					•
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any Injury or other		20a. Method of Disposition 1 □ Burial 2 X Cremation	Removal from State	20b. Place ceme	of Dispo	sition (Name of natory or other place	ce)	Date	20c. Loca	tion - City or	Town, State
Itim iit. Pag artment ortant: Injury		4 □ Donation 5 □ Other (Sp. 21. Signature of Fungyal SerVice V	(cify)	Bayvi		rematory  . Name and Addres					Maryland
Demii Depal Impol		· west still	1401	113		221 Gray					
		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each l	ed the death. D line.	o not ent	er the mode of dyin	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
Physician /Medica		Immediate Cause (Final disease or condition resulting in death)	a. Acu	te r	ena	1 failu	re	-			1 month
Examine		Conventially list conditions	h Chro		rono	y insi	Affici.	ency			> 6 months
per tyles	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequenc	ce of):		) 1				
60, be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	s a consequenc	ce of):		-				
	dical	,	d								
Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e pf pregnancy 2  Fetal dea at time of death	ath 3□	Ectopic pregnancy Other (specify)	,		23	d. Date of del Month	ivery Day Year
S, P es that gned b	by Pł	Part II. Other significant condition	4 .	but not resulting	g in the ur	nderlying cause give	en in Part I.				the cause of death?
cord requir	eted	Cardiom	y o pathy	-						No 3□Pr	obably 4 Unknown
Rec he law e has t	Completed							per	opsy ormed?	prior to death?	utopsy findings available completion of cause of
Vital I sician: Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?					26. Place of De	1□ Yes ath (Check only	2 No   one)	1 □ Yes	2 No.
Or V Physic this ce	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati	ient 2 ER/	Outpatien		4 or Nursing I	Home 5 Res			cify)
ion ath. r: After e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	ay Year)	Injury	Worl	yan k? Yes 2∐No	28d. Describe	now injury	occurred	
Division or Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place of in building, e	tc. (Specify)		eet, factory, office		City or To	iwn, State)		ural Route Number,
e Hosp 24 ho e Fune letely f	Medical	29a. Certifier 1 CertifyIng (Check only 2 Medical E.	Physician: To the best caminer: On the basis of and manner st	of examination	and/or in	occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time	e cause(s) a e, date and p	nd manner as lace, and due	s stated. e to the cause(s)
To th vithin To th comp	Me	29b. Signature and title of certifier	MD			29c. License		2-			th, Day, Year)
100		▶ Begun		dab_(u ^-	) (T:::	000	53928	1. 11/4	,	2/20	· /
		30. Name and address of person w	ELVEDERE	AVE	1) (Type,	ALTIMOR	E, MD	-212	15		
。S Regis		Ot Data Blad (Manth Day Votal) :	- 20 Degist	raria Cianatura							
DHMH 17 Rev 1		NUV 2 8	2007	was do	1	nests !			-		
					OR	IGINAL					

State of Maryland / Department of Health and Mental Hygien 20071 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** ADRIENNE SUSAN ALDERTON 2 7-2007 10:20A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany 713 Elm Street Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** <sup>4</sup>1957 Hours Sep 19. Months Days 1 ☐ M 2 🖫 F 213-80-1591 50 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County irthan "natural", or itema 23a or 28a-1 ahow tra Madical Examinar must be cottilled at Allegany Cumberland MD 1 Ves 2 No Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 713 Elm Street Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) self-employed painter 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Right and Mental Hy Right and Mental Hy any injury or other traumatic avent sones. 17. Father's Name (First, Middle, Last) Be Mary (Morris) Alderton William Howard Alderton 19b. Mailing Address (*Street and Number or Rural Route Number, City or Town, State, Zip* Code), 748 Maryland Avenue Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) brother John Alderton 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 11/23/2007 Cresaptown MD 4 ☐ Donation \_5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nam Straffetti Fütteral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only/one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer Kenal **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of o rtifie November 21,2007 36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 SETON DR. CUMBERLAND, MD 21502

DHMH 17 Rev 1/2001

State Registrar

POONAL

2007

VIKRAMADITYA 31. Date filed (Month, Day, Year)

, M.D

32. Régistrar's Signature

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Uses only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, bearing to instruction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No the 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown Emphy sema 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2**E** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 25,No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ို completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bry enp MDD 42580 November, 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parmy it Auj la, MD. 5632 annapolis Rd., Suite 13, Bladensburg, MD. 20710

31. Date filed (Month, Day, Year)

32. Registrar's Signature State NOV 1 3 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 9 2007 WILSON ANDREWS NOVEMber 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death DOCTOR'S COMMUNITY HOSPITAL PRINCE GEORGE'S LANHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05–15–1938 Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 142 M Conetoe, N.C. 239-66-2193 69 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 3416 Brinkley Road # 202 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: **Black** 3 € Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker Private Industry 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester Andrews Betty E. Boyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3416 Brinkley Rd. #202 Temple Hills, MD 20748 Teresa R. Andrews/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐8urial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 11-15-2007 4 Donation 5 Dother (Specify) Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary Hidgman M01374 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiena O O T

		-	For State Of Maryland / State Registrar	Department of Health and It  Certificate of Death	Reg. N	/
4			Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ay Year 3. Time of Death
100 24.50	Physicia /Medic	al .	Marcella Rose ARD		Nov. 13	2007 10:07 P M
The second	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
-	Funeral		Homewood Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last b	Williamsport irthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	Washington  9. Birthplace (State or Foreign Country)
	Director		220-64-2158 1 M 2 F 92	Yrs. Months Days Hours Min.		915 Pennsylvania
	put N		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	vn or Location		10d. Inside City Limits
	Maryle f sho ed at	ō		rstown		1 □Yes 2¥[□No
	r 28a- notif	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Country?
	th witl 23a o 1st be	a D	1643 Woodlands Run	21742		USA
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl</li> </ol>	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Mamed 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
Maryland 21215-0036	2 hou latura leal E	ted		a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b.	Kind of Business/Industry
215	ithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	,9	
121	e filed wi al Hygier other th vent, the		0-10 0	Homemaker 18. Mother's Nan	ne (First, Middle, Maide	Her own home
and	d be fi	Be	Franklin D. Thompson		nn Corigan	,
Z	2 should be and Mental is marked a	ဥ		b. Mailing Address (Street and Number or Ru		or Town, State, Zip Code)
	1 and 2 Health a tem 27 is		Eileen Harbaugh (Daughter 1	6200 Broadfording Ro	ad, Hagerst	own, Md. 21740
ore	of He of He if Item		20a. Method of Disposition  1 ☐ Burial 2 MCremation 3 ☐ Removal from State  20b. Place ceme.	of Disposition (Name of ery, crematory or other place)	Date 20c.	Location - City or Town, State
Baltimore,	. Pages tment of I tant: If Ite jury or of		4 □ Donation 5 □ Other (Specify) Hage	rstown Crematory 11/		gerstown, Maryland
Bal	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Licensee		Minnich Fur	
			23a. Part1. Enter the disease, or complications the death. Do shock, or heart failure. List only one cause in each line.			own, Maryland 21740 Approximate Interval Between
	Physician		shock, or heart failure. List only one cause in Lach line. Immediate Cause (Final disease or condition	No ( DEMINTIA		Onset and Death
ä	/Medical		resulting in death)  a.  Du 1 (or as a consequence	e of):		
3.	Examiner	<u>.</u>	Sequentially list conditions, b. Due to or as a consequence	of:		
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	e oij.		
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68760,	tificate be executed ig physician and as the burial-transit	edical	d			
	ertifice ing ph e as tl		IF FEMALE:			
Вох	leath certi attending I for use a	Physician/N	23b. Was decedent pregnant in the past 12 months?			23d. Date of delivery  Month Day Year
Ö	that the dened by the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	0		
ر. ت	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	by Pł	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death?
ord	w require been sig should b		FINATERIAN V		1 ☐ Yes	2 No 3 Probably 4 Unknown
ecc	law r nas be e 2 sh	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
al F					1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No 1 ☐ Yes 2 ☐ No
or Vital Records,		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2 ☐ ER/	Other: A	ath <i>(Check only one</i> ) Home 5□ Residence	6 ∏Other (Specify)
יסר	g Phys ter this neral dii	n: To	27. Manner of Death 28a. Date of Injury 28th	D. Time of lnjury at Work?	28d. Describe how in	
sior	Attending I r death. ector: After by the funer	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	는 를 들	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	farm, street, factory, office	City or Town, St	and Number or Rural Route Number, ate)
	oital urs a erai		29a. Certifier 1 Certifying Physician: To the best of my knowled	ge, death occurred at the time, date and plac	e, and due to the cause	e(s) and manner as stated.
	To the Hosp within 24 ho To the Fune completely f	edical	(Check only one)  Medical Examiner: On the basis of examination and manner stated.			
	To the within To the comple	Σ	29b. Signature and little of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
•	AD.		may musica pine	VIVO Print		11/17/00)
	\		30. Name and address of person who completed cause of death (Item 23:	424 Pa AU 1001	1 HAGGER	Town Mo E(XF)
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 2		1
	Regist	rar	NUV A U ZUU! I Dans A	150 Ball 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2007, **Physician** Month NOV. 7, **JAMES** 10:10A M HENRY ALLEN, SR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 18504 Traxell Way MONTGOMERY Gaithersburg | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr. 20, 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F Director 228-42-2312 73 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Montgomery Germantown 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 18003 Mateny Road 20874 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Yes 2 N If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify: Completed by 53-55 Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) State of Elementary/Secondary (0-12) College (1-4or 5+) Tax Examiner New Jersev 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hampton M. Scott Gracie Clemens 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai once, Anita Tabor (Daughter) 18504 Traxell Way, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 ☐ Cremation Removal from State 4 Dopation 5 Dother (Specify) Gedar Lawn Cem 11/16/07 Paterson, NJ 21. Signate of Funeral Sec 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Infarction hour /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease
Due to (or as a consequence of) 10 years Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughter Other: 4 Nursing Home 5 Residence 6 Other (Specify) Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.0. or Vital Records. Division

death certificate be executed attending physician and for use as the burial-tran signed by the a page 2 al or Attending F after death. I Director: After d in by the funera After filled in by Funeral Hospital 24 hours within 2 To the

show

1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 is marked other than "natural", or Items 23s

Baltimore, Maryland 21215-0036

6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier anil

29c. License number D25881 29d. Date signed (Month, Day, Year) 11/8/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joann Urquhart, M.D. 9711 Medical Center Dr, Rockville, MD 20850 31. Date filed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

13 2007 NOV



10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month November 12, 2007 **Physician** 11:00 A M KABLER DALE ASHWELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 № M 2 🗆 F June 5, 1934 Virginia 215-30-8150 Director 73 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 TYes 2 No Director Maryland Howard Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17380 Frederick Road 21771 United States Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 🖾 No Specify: Specify. ģ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation nit. Pages 1 and 2 should be filed within 72 ho artment of Health and Mental Hygiene. ortant: If Item 27 Is marked other than "natu injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 11 School Bus Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Ashwell Inez Snow ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy L. Ashwell / Wife 17380 Frederick Road Mt. Airy, Maryland 21771 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Stauffer Crematory 4 Donation 5 Dother (Specify) 17, 2007 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the diseate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LIVER 71GEAR **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? the funeral director, page 2 s 1 ☐ Yes 2 ☐ No 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 2 1 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t or Attending Injury t Natural 5 Pending investigation 1 Tyes 2 No 2 Accident death after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 124 hours a's 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Culwell Drive Mt. Airy, Maryland 21771 Ronald E. Miller, M.D.

State

Registrar

32. Registra's Signature 31. Date filed (Month, Day, Year) NOV 1 5 2007 ▶

126499

11-13-07

	1	For State Registrar	State of Maryland /		nt of Health and te of Death		leg. No.	37947
g (8) P		Decedent's Name (First, Middle, Las	)			2. Date of Dea Month	th Day Year	3. Time of Death
siciar	_	David Anthony Ain	sworth			November		01:45 A M
edica ıminei		4a. Facility Name (If not institution, give	street and number)	4b. City	, Town, or Location of Dea	th	4c. County of Death	1
v 156	-	406 Heather Way		Hav	re de Grace		Harkord	
ral		5. Social Security Number 6. Se		birthday) If Und	er 1 Year If Under 24 Hrs		9. Birth	place (State or Foreign intry)
tor		220-92-4068	<b>X</b> M 2□ F 57			Feb. 28		gland
927	-	Usual Residence of Decedent  10a. State 10b. County	10c City To	own or Location				10d. Inside City Limits
M. Curorel Director								1 ☐ Yes 2 📉 No
1	<u>ں</u> ⊢	Maryland Harford	Havre	de Grac			10g. Citizen of What Co	into/?
c	5	10e. Street and Number			ip Code			artity.
0	<u>a</u>	406 Heather Way	40 Way Dansday Francis U.S.		078 edent of Hispanic Origin? (		ngland  14. Race - Amer	rican Indian.
1	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No	If Yes, sp	ecify Cuban, Mexican, Pue	nto Rican, etc.)	Black, White	
1	Dy	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specity: Who	ite
		15. Decedent's Ed		6a. Decedent's Us	ual Occupation		16b. Kind of Business/l	ndustry
1	Completed	(Specify only highest gra	de completed)	(Give kind of w life. DO NOT	vork done during most of wo use retired)	orking		
	E	Elementary/Secondary (0-12)	College (1-4or 5+)	hemist			Carbon Indi	เมล้าเน
		17. Father's Name (First, Middle, Last)	,		18. Mother's Na	me (First, Middle,		
0	o Re	Fred Ainsworth			May (	Frain)		
F	-	19a. Informant's Name/Relationship	ype, Print)	9b. Mailing Addre	ss (Street and Number or F		or, City or Town, State, Z	ip Code)
		Joanne Ainsworth	Spouse.	406 Hea	ther Way Hav	re de Gra	ice. Marular	nd 21078
	-	20a. Method of Disposition	20b. Place	of Disposition (Natery, crematory of	ame of	Date	20c. Location - City or	Town, State
		1 ☐ Burial 2 <b>屬</b> Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Ferris		12/2007	West Cheste	PA PA
	}	21. Signature of Funeral Service Licen			and Address of Facility me	an Mitche	ell Smith Fu	ineral Home
		12.	WI		. Washington			
	$\dashv$	23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused the death. I					Approximate Interval Between
	dicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	ce of):				
1	ed							
1-1-1	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3□Ectopic			23d. Date of del Month	ivery Day Year
4	F.	Part II. Other significant conditions of	ontnbuting to death but not resulting	g in the underlying	cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
	g Q					10	Yes 2 □ No 3 □ Pr	obably 4 Hunknown
	Completed					24a. Was	an 24b. Were au	itopsy findings available
1	ᇤ						rmed? death?	completion of cause of
						1 Yes		2[4No
10	Be	25. Was case referred to medical examiner?	Hospital:		Other	eath (Check only o		-4.1
	၉	1 ☐ Yes 2 ☐ No  27. Manner of Death	1   Inpatient 2   EH	Outpatient 3 D	DUA 4 Nursing		dence 6 Other (Spe	ciry)
	o	1 Matural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. 5000.120		
	=	2 Accident investigation 3 Suicide 6 Could not b	1			28f. Location (	Street and Number or Ri wn, State)	ural Route Number,
	ertification:	4 Homicide determined						
(	ပ ၂	4 Homicide determined	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	dge, death occurr and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	Medicai Certifica	4 Homicide determined  29a. Certifier (Check only 2 Medical Exar	ysician: To the best of my knowle	and/or investigati	ed at the time, date and pla on, in my opinion, death oc 29c. License number	ce, and due to the curred at the time,	cause(s) and manner as date and place, and due 29d. Date signed (Mont	o to the cause(s)
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pletely filled	edicai C	4 Homicide determined  29a. Certifier (Check only one)  Certifying Pr 2 Medical Exam	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	and/or investigati	on, in my opinion, death oc 29c. License number	curred at the time,	date and place, and due 29d. Date signed (Mont November 1	h, Day, Year)

		State of	Maryland /				lental Hygie	2001	37948
-		Registrar  1. Decedent's Name (Eirst, Middle, Last)		Cer	tificate of l	Dealii	Reg. 2. Date of Death	No.	3. Time of Death
Physici /Medic		Elizabeth	Alve	24			Month (	Day, Year	701:47A.M.
Examin		Agracility Name (If not institution, give street and num.	ber)	Jap	4b. City, Town, or	Location of Death		4c. County of Dea	th AAACT
Funeral		5. Social Security Number 6. Sex 7	7. Age (In yrs. iast i	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Bir	thplace (State or Foreign
Director		579-40-8051	75	Yrs.	Morrors Days	Hours Will.	4/4/1932		hington, DC
iand ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	cation				10d. Inside City Limits
Mary	ctor	Maryland Wicomico	Sa	alisb	oury				1 XYes 2 □ No
ith the	Directo	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
sath w	erai	1009 Riverside Dr.	dent Ever in U.S.	13 V	218	O1 lispanic Origin? (Sp	acity Yes or No-	USA 14. Race - Ami	erican Indian.
portition is intensity facing a LL 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if tem 27 is marked other than "natural", or items 23a or 28a-f show spinjury or other traumatic event, the Medical Event and must be notified at ance.	by Funerai	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Dece Armed For 1 Yes 2 If Yes, Give Year or Da	ces? 2 <b>X</b> No	lf	Yes, specify Cuba	Specify:	Rican, etc.)	Black, Whi	
2 hou	ted	15. Decedent's Education		Sa. Deced	ent's Usual Occup	ation	168	b. Kind of Business	/Industry
ithin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-	4or 5+)			during most of work		naretmant	7
ited w dygier ther th		11 – 17. Father's Name (First, Middle, Last)	F	Kesio	lent Mana		e (First, Middle, Mai	partments	
should be f and Mental H marked of	To Be	John Hilbert	1.			Virgini	a Davis		7-0-11
d 2 sh d 2 sh th and th and traum		19a. Informant's Name/Relationship (Type, Print)  Joseph Alvey Jr/son					al Route Number, C t. Airey,		
s 1 and f Health flem 27 other tr	1.5	20a. Method of Disposition	20b. Place	of Dispos	sition (Name of			c. Location - City or	
Pages nent of I		1	Fork Ceme	Epis tery	copal Ch	ürch 11/1	2/07	Doswell,	VA
permit. Departrimports any inju		21. Signature of Funeral Service an Insee	CENP	22 H	Name and Addre	ss of Facility Funeral H Hill Rd.,	ome Profe Salisbur	ssional A	Association 304
		23a. Part1. Enter the disease, or complications that ca shock, or heart lailure. List only one cause on ea	used the death. Duch line.						Approximate Interval Between Onset and Death
Physician	7 1	Immediate Cause (Final disease or condition resulting in death)	28.0.80	(ear	Eric C	ordica Na	Jecolar ,	Lisers	
/Medical Examiner		14.	_	⇔ ા્): દિલ	W-16				
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	or as a consequence		<u> </u>				
ecuted and transi	Examiner			1)					
icate be executed physician and sthe burial-transit	a E	Due to (c	or as a consequenc	ce or):					
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h cert	M/us	23b. was decedent pregnant	come of pregnancy	ath 3.□	Ectopic pregnancy	,		23d. Date of de	
Physician: The law requires that the death certificate has been signed by the attending rithis certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Me		ant at time of death		Other (specify)			Month	Day Year
that the ed by detac		Part II. Other significant conditions contributing to de	ath but not resulting	g in the ur	nderlying cause giv	en in Part I.	23e. Did tobac	cco use contribute	o the cause of death?
w requires the been signed should be o	ed by	Chronic Obstruc	rue Pr	.lce	ellery	Desens	e 1 Yyes	2 □ No 3 □ P	robably 4 Unknown
as bee	Completed	Dicheres Melli	Tis				24a. Was an autopsy	24b. Were a	utopsy lindings available completion of cause of
The The cate his	Com						performe	d?   death?	s 2 No
VII.d ician: certific ector.	Be	25. Was case referred to medical examiner?  Hospital:	3.0		• 3□ DOA Oth	ar.	h (Check only one)		
Phys r this rai dir	: To	27. Manner of Death 28a. Date o	f Injury 28t	Outpatien o. Time of	1 3L DOA	4   Nuising no	ome 5 Residence 28d. Describe how		ecify)
nding ath. r: Afte e fune	atior	1 Natural 5 Pending (Month 2 Accident investigation	h, Day Year)	Injury	Wor	rk?  Yes 2 □No			
lor Atteater des Directo	Certification:	3 Suicide 6 Could not be 28e. Place	of Injury - At home ig, etc. (Specify)	, larm, str	eet, factory, office		281. Location (Stree City or Town,		dural Route Number,
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director. page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one)	sis of examination						
To the within To the	Me	29b. Signature and title of certifier			29c. Licens	se number	29d	. Date signed (Mor	ith. Day, Year)
6		7/lemon.	(به 🖸		H	5686	5	11/8/	07
SU		30. Name and address of person who completed cause		280		1	.(		0
	ato	31. Date liled (Month Pay, Year) 2007 32.	gistrar's Signature	551	Deer	strand	HOSP 17	JH MT	2 2 (80)
Sta	ne :	NUV U 9 2007	Out to	1 1		· ·	A B W	- 61	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 19 0825 AM 2007 Sylvia Lorraine Blackburn 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street and number) Ceci1 E1kton SunBridge Care Center If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Dey, Year) AUG 23, 1920 7. Age (In yrs. lest birthday) 5. Social Security Number Days Hours 1□M 2\ F Pennsylvania Yrs. 212-16-4396 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 21 No E1kton Ceci1 10f. Zip Code 10g. Citizen of What Country? United States 137 Arbutus Street 21921 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 

Widowed 4 □ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Waitress/Cook Restaurant 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Elsie Hall William Watson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeanne L. Smith/Niece 137 Arbutus Street, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State NOV. 23, 20a. Method of Disposition 1 Buriel 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery 2007 Port Deposit, MD 22. Name and Address of Fecility Hicks Home for Funerals, P.A. 21. Signeture of Funeral Service Licensee 103 W. Stockton Street, Elkton, Maryland 21921 Marra 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) CARDIAL ARREST Due to (or as a consequence of): YIZARS ATRIAL FIBRILLATION CHF Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Injury 5 Pending 1 🗌 Yes 2 No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mantal Hygiene.

Int if item 27 is marked other than "natural; or items 23a or 28s-f show if health and Mantal Hygiene. Item 27 is marked other than "naturel", or i other traumetic event, the Medical Exami 3altimore, Maryland 21215-0020 Be ò Department of Important: If any injury or **Physician** /Medical Examine ( Physician/Medical Examiner To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humal transmit. Division of Vital Records, P.O. Box 68760, þ Completed Be edicai Certification: To

**Physician** 

/Medical

Examiner

10a. Stete

Maryland

11

10e, Street and Number

**Funeral** 

Director

me 23a or 28a-f ehor

Director

Funeral

Completed by

State Registrar 29b. Signature and title of certifier V. Nayou D 29c. License number 10069732 29d. Date signed (Month, Dey, Year) 11/19/57

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Narayana V. Pula, M.D., 118 North Street, Elkton, MD 21921

31. Date filed (Month, Day, Year)

1 Yes 2 No

27. Manner of Death

1 Naturat

2 Accident

3 🗌 Suicide

29a. Certifier (Check only one)

4 Homicide

NOV 2 8 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11/18/2007 Physician 6:00 AM Dorothy G. Boland /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Easton <u> William Hill Manor</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 01/17/1918 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1 □ M 2 🗙 F 89 Illinois Director 342**-**07-6159 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 XYes 2 No Directo Denver Colorado Denver 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. USA 80211 2825 West 32nd Avenue Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 🛣 No Specify ō þ 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other than "natu 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) Be Gertrude Smith Frank J. Sullivan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9241 Deepwater Pt. Rd., St.Michaels, MD 21663 Kathleen Boland/Daughter other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State MidShoreCremationCenter 11/19/2007 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility id Shore Cremation Center .O. Box 1464, 2272 Hudson Rd., Cambridge, MD 21613 ature of Funeral Service Licensee or complications that caused the death. Do not letter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 menths? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown stributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ Completed Be Certification: To

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, nours after death.
neral Director; After this
filled in by the funeral di within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

1 2 4	Pordisn	1 Yes 2 No 3 Probably 4 Unknow
Morrie 6 (	estructive Palmoney Disease	24a. Was an autopsy performed?  1 ☐ Yes 2 📆 No 24b. Were autopsy findings availab prior to completion of cause of death?
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year) Injury Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Usem 23a) (Type, Print) Hill Retirement CtR.

William

Registrar's Signature

32.

State Registrar

3

29a. Certifier

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nov 16, 2007 **Physician** 7:24pm Bowman Marie Rose /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine Allegany Devlin Manor Nursing Home Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y NOV 21, 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Months Hours 70 234-52-9567 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. Count Cumberland MD Allegany 1 ☑ Yes 2 ☐ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 10301 Christie Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1□Yes 2□Xo altimore, Maryland 21215-0036 Specify: Completed by white 3 ☐ Widowed 4 ₺ Divorced 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Sandor Harry Tucker ဥ Mailing Address (Street and Number of Flural Route Number, City of Town, State, Zip Code) 653 Burtons Cove Way Annapolis MD 21401 19a. Informant's Name/Relationship (Type. Print) niece permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai Tracy Leahy 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State Calvary Cemetery 11/28/2007 WV Grafton 1 □ Dun.... 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home for Bartlett Funeral Home, Grafton, WV 26354 23a. Part1. Enter the disease shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner that the death certificate be executed burial-transit and P.O. Box 68760.4 Due to (or as a consequence of): physician the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Khanna

NOV 2 8

DHMH 17 Rev 1/2001

29c. License number

0054004

29d. Date signed (Month, Day, Year)

21502

and manner stated.

32 Registrar's Signature

Wat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 4,2007 **EPHRON** BROWN /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner DOCTORS HOSPITAL LANHAM PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex **Funeral** Months Days Hours Min. 1**X** M 2□ F 75 JUNE 24 1932 SOUTH CAROLINA 251-48-2542 Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a. State Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 →Yes 2 No Director MD PRINCE GEORGE'S BOWIE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3714 20716 EXCALIBUR COURT # 201 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2X No Specify. ģ Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT SUPPORT ENGINEER 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LESLIE CAMPFIELD LOUIS BROWN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BENISE JONES/DAUGHTER 8003 ORCHARD PARK WAY BOWIE, MARYLAND 20715 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/2007 SALLEY, SOUTH CAROLINA ZION HILL CHURCH CEM: 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic one year **Physician** /Medical Examiner 3 month 4 denocarcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner rostate be execute burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the nse 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a detached i 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ OBSTRUCTIVE PULMONARY 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No 2 ER/Outpatient 3 DOA 1 Tes Certification: To this 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Postifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier



29c. License number

D0058213

		For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artmer rtificat	nt of H	ealth a Death	and M		gienę Reg. No		37	1953
Physici	an	Decedent's Name (First, Middle,								2. Date of Dea Month	Da		r	ne of Death
/Medic		Bernic		В.			ennie			November				25 P M
Examin	er	4a. Facility Name (If not institution, 11 Cree Drive				Forest	t Heig				Pr	County of De	orge's	
Funeral Director		366-09-2552	3. Sex 1 □ M 2 🖾 🛣	7. Age (In yrs.	last birthday) 96 Yrs.	Months	n 1 Year Days	If Under: Hours	Min.	8. Date of Birt (Month, Da Sept. 23	y, Year) 191	1 9.8	intholace (Si Country) MICh	igan
and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation		-					10d. Insi	de City Limits
Marylan f show	ō	Maryland Prince	George's	Fo	rest Hei	ghts							1 🗆	Yes 2 □ No
r 28a	Director	10e. Street and Number				10f. Zig	o Code				10g. Cit	izen of What (	Country?	
ours after death with the Maryla ral', or iteme 23s or 28s-f shov Examinar mast be notified at		11 Cree Drive				2	20745					USA		
r dea	Funerai	11. Marital Status	Armed	ecedent Ever in U Forces?	l.S. 13.	Was Dece If Yes, spe	dent of His	spanic Orig n, Mexican	gin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	-	14. Race - An Black, Wh		an,
s afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ₩ Widowed 4 ☐ Divorced	id 1 □ Yes If Yes, 0 Year or	s 2 No Give		1 🗆 Yes	NXX)	Specify:				Specify:	White	
72 hours "natural",		15. Decedent's	Education		16a. Dece	dent's Usu	al Occupa	ition			16b. K	ind of Busines	s/Industry	
nin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	1	d) (1-4or 5+)	(Give			uring mosi )	t of workir	ng				
giene th	Com	12	00030			Home	maker						Home	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene.  Department of Heelih and Mental Hygiene.  Department of Heelih and Mental Hygiene.  Proportions: If them 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar minatibe notified at once.	To Be (	17. Father's Name (First, Middle, L Ormand E		ble					er's Name Irtha	(First, Middle, Marie		sumame) nknown		
2 should be mand in man		19a. Informant's Name/Relationsh	p (Type, Print)		19b. Mailir	ng Addres	s (Street a	nd Numbe	er or Rura	Route Number	er, City o	or Town, State	, Zip Code)	
1 and 2 Heelth tem 27 i		Sharon Weber / Dau	ghter	100				Clinto		ryland	2073			
Pages 1 nent of H nnt: if ite		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal fro	m State	Place of Dispo cemetery, crea	matory or	other place			ate		ocation - City o		
t. Partmen		4 Donation 5 Other (Sp			edar Hil				11/15,	/200/	Sui	tland, M	aryland	1
permit. Departimport import		21. Signature of Funeral Service L	alu I	<b>1</b> .				s of Facilit		on Hill,	Mary	land 2	0745	
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	omplications ha	caused the dea									Approx	ximate al Between
Physician		Immediate Cause (Final disease or condition	iny one cause of	Falur	to	Thre	ine						Onset	and Death
/Medical		resulting in death)	Due I	o (or as a consec	quence of):	0	-0 .1	lises	,					
Examiner		Sequentially list conditions,	b. ————	o (or as a consec		near	Ta	w	W.				-	<u> </u>
nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	o (or as a consec	(transe or):									
be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a consec	quence of):									
ate be ohysicies the buri		N.	d											
ng ph	Physician/Medical	IF FEMALE:												
leath certifica attending ph	lan/I	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregn birth 2 Feta	al death 3	Ectopic						23d. Date of d Month	lelivery Day	Year
he de	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4⊟Pre 9⊟Uni	gnant at time of o known	death 5L	Other (s	рөсіту)							
The law requires that the death certificate lie has been signed by the attending phys age 2 should be deteched for use as the		Part II. Other significant condition	s contributing to	death but not res	sulting in the u	nderlying	cause give	n in Part I.		23e. Did t	obacco	use contribute	to the caus	e of death?
w requires been sign should be	ed by									10	Yes 2	X No 3□	Probably	4 Unknown
aw requ	plet									24a. Was		24b. Were	autopsy fino	lings available n of cause of
	Completed									perfo	med?	death	? es 2□No	
sician: T certificet irector, pa	Be (	25. Was case referred to medical examiner?	Ha anitali				100		of Death	(Check only o	one)			
Physic this o	10	1 ☐ Yes 2 ĀĀNo 27. Manner of Death			ER/Outpatier 28b. Time o			4   140		ne 5XXResid 28d. Describe I			oecify)	
ding After funer	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		te of Injury onth, Day Year)	Injury	м	28c. Injury Work 1 □ 1	:?` ∕es 2 🗆			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,, 0004.104		
or Attending Physician: ifer death. Director: After this certification by the funeral director.	Certification:	3 Suicide 6 Could not determine	ot be 28e. Pla	ce of Injury - At h	ome, farm, str fy)	reet, factor	y, office		- 1	28f. Location (: City or Tol			Rural Route	Number,
To the Hospital or Attanding Physician: within 24 hours site death within 24 hours after death of the Funeral Director. After this certific completely filled in by the funeral director,	edical Ce	(Check only 2 Medical E	xaminer: On the	the best of my know basis of examina	owledge, deat ation and/or in	h occurred	at the tim	ne, date an pinion, dea	nd place, a	and due to the	cause(s	) and manner d place, and d	as stated. ue to the ca	use(s)
the I	Medi	one) 29b. Signature and title of certifier	and m	anner stated.			c. License					ite signed (Mo		
Z M F S	_	Abdullan A	1. Adl	Olu				086	0		11	1,2 /1	,	-
2/1		30. Name and address of person w	no completed of	use of death (Ite	m 23a) (Tvoe					, <u>, , , , , , , , , , , , , , , , , , </u>	1 (	10/		20248
(0)		Abdulbose in	Hall	MAI	MD	44	ا (ما،	1 610	SRALIC	h Ava	201	Temple	Hills,	MD
Sta Registr		31. Date filed (Month, Day, Year)	4 32	. Registrar's-Sign	ature							•		

Division or Vital Records, P.O. Box 68760,

3altimore, Maryland 21215-0036

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

NOV 1 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Docteri d nt 32. Registrar's Signature 31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

MIRES

29d. Date signed (Month, Day, Year)

Ceredatora led

			For State	State of Maryland / [				Mental Hy	giene	9	
			Registrar		Cer	tificate of L	Death		Reg. No	2007	37955
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of De Month	Da	y Year	3. Time of Death 1:20 P M
	/Medic		Verta Frances Bec  4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	Nov 9,		. County of Death	
	Examin	e:	Crescent Cities N	,			rdale			rince Ge	
-	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last bir	rthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da			place (State or Foreign
Ь	Director		234-32-0709	]M 2 <u>R</u> F 89	Yrs.	Months Days	Hours Min.	Oct. 2	8, 1	918 Mann	gton, WV
	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Loc	ration					10d. Inside City Limits
	laryla sho ed at	ō	,	,							1⊠Yes 2□No
	the N 28a-i	Director	Maryland Prince G	eorge s   nya	LLS	7ille 10f. Zip Code			10a. Cit	tizen of What Cou	intry?
	y with	Ö	5805 42nd Avenue			207	Ω1			USA	•
	ms 2	Funeral		12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi	spanic Origin? (S	pecify Yes or No	)-	14. Race - Ameri	
Maryland 21215-0036	d within 72 hours after death with the Maryland giene. r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2% No If Yes, Give Year or Dates:		Yes, specify Cuba  ☐ Yes 2█ No	Specify:	o Rican, etc.)		Black, White,	
2-0	72 ho natur lical	Completed	15. Decedent's Edu (Specify only highest grad		. Deced	ent's Usual Occupa	ation Juring most of war	kina	16b. K	ind of Business/Ir	ndustry
21	within lene. than "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	kind of work done d O NOT use retired,		King		0 77	
121	e filed w al Hygier other th vent, th		6			Homemak	er 18. Mother's Nan	no (Eirot Middle	Maidan	Own Hom	ie
and	Ibe fi	Be	17. Father's Name (First, Middle, Last)  W. H. Gump					Myres	, warden	i Surname)	
Ž	hould nd Me mark matic	은	19a. Informant's Name/Relationship (T)	ne Print) 19h	Mailin	g Address (Street a			er City i	or Town State Zi	in Code)
Na	nd 2 s Ith an 27 is		Henry Beckert - H	·		42nd Ave					781
	s 1 ar f Hea Item 3		20a. Method of Disposition			sition (Name of natory or other place		Date		ocation - City or T	own, State
e E	Page ent o nt: If		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval nom State		L Cemeter		2/07	Sui	tland, M	aryland
Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, i once.		21. Signature of Funeral Service Licens			Name and Addres				-	nore Ave.
m	permi Depar Impor any ir		Manho	File	Ga	sch's Fur	neral Hor	ne, P.A.	Нуа	attsville	e, MD 20781
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused the death. Done cause on each line.	not ente	er the mode of dying	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Dementia						1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	of):						
	LAGITITIE	<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	26\						
	ted nsit	Examine	Cause (Disease of Injuly)	Due to (or as a consequence	OI).					- 04	
-	execu al-tra	xar	that initiated events resulting in death) Last	Due to (or as a consequence	of):						
68760,	cate be executed physician and the burial-transit	dical		1							
9		ledi									
Вох	death certific e attending p d for use as t	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3	Ectopic pregnancy				23d. Date of deliv	,
	0 0	sicis	in the past 12 months? 1 ☐ Yes 2 🛣 No	4□Pregnant at time of death		Other (specify)				Month	Day Year
P.0.	that the de ned by the a detached t	Phy	9 Unknown		41.			00 5111			
	es igr	by	Part II. Other significant conditions co Stroke	ntributing to death but not resulting i	n the un	derlying cause give	n in Part I,			use contribute to	the cause of death?
Ö	w requir	sted							165 2	1 100 3   100	——————————————————————————————————————
3ec	e la has	Completed	Atrial fibrillati	on			-	24a. Was		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
a	ician; The l certificate ha ector, page		05.14					1□ Yes	2 <sup>2</sup> No		2 □ No
₹		o Be	25. Was case referred to medical examiner?  1 Yes 2X No	lospital: 1 ☐ Inpatient 2 ☐ ER/Ou	strations	Othe	26. Place of Dea			о Пон <u>(о</u>	· .
0	y Physer this eral dil	$\vdash$	27. Manner of Death	28a. Date of Injury 28b.	Time of	28c. Injury Work		ome 5 ☐ Resi 28d. Describe		6 ☐Other (Speciary occurred	ity)
ion	Attending r death. ector: After by the fune	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		:? ∕es 2 □ No				
Division or Vital Records,	Atte er des ecto by th	ifice	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, fa building, etc. (Specify)	arm, stre	et, factory, office		28f. Location ( City or To		nd Number or Rui	ral Route Number,
	tal or	Certification;		building, etc. (opeony)			(4	Ony or 10	wii, Olai	<del></del>	
	the Hospital hin 24 hours a the Funeral npletely filled		(Check only 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination ar							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29b. Signature and the of certifier	and manner stated.		29c. License				ate signed (Month	
	vitl To	_	Signature at the line of the l	W ND.			64208		∠3U. D8	11/9/07	, vay, real/
	(		20 Name and address of person who	ampleted cause of death /ltem 00-1	/Tuna *					11///0/	
1	(I)		30. Name and address of person who con Saadia Husain, MI				le. MD	20737			
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatule	100	,					
	Registr		MOV 1 3 2007	Treman D. Ope	1						

DHMH 17 Rev 1/2001

		-	_ State	State of Mary		artment of H <i>rtificate of I</i>			giene Reg. NoO	0 7	07056
	eş.		Registrar  1. Decedent's Name (First, Middle, Last)			timodio or i	- Journ	2. Date of De		U-/-	3. Tinle of Death
*	Physicia			ATT Tag				Month	er 15 à	Year	10:36 PM
	/Medic Examin		Alvin Bernard BIN  4a. Facility Name (If not institution, give sti			4b. City, Town, or	Location of Death	y voucinip	4c. County		
	Examini	75/2	Washington County			Hagerst	own		Washi	ingtor	n
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year		8. Date of Birt (Month, Da	th		lace (State or Foreign
	Director		220-42-5126	M 2□F (	52 Yrs.	Months Days	Hours Will.	April 4		Mary	*/
	p.		Usual Residence of Decedent	140	c. City, Town or Lo	antion		_		1	0d. Inside City Limits
	arylaı show d at	_	10a. State 10b. County	10	C. City, Town of Lo	cation				''	17 Yes 2 □ No
	he M 8a-f otifie	ecto	Maryland Washingt	on	H	agerstown		1	10g. Citizen of	What Cour	atn/2
	with t	直	10e. Street and Number						rog. Citizen or	Wilat Coun	idy:
	eath v	Funeral Director	13071 Little Hayde	n Court 2. Was Decedent Ever	in U.S. 13 V	Vas Decedent of H		ecify Yes or No	USA - 14. Rad	ce - America	an Indian,
	item item ner r	Ę.	11. Marital Status  1 □ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No	10.0.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Bla	ck, White,	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 21√2 No	Specify:		Specif		ite
Ö	2 hou atura cal E	ed	15. Decedent's Educa	ation	16a. Deced	dent's Usual Occup	ation		16b. Kind of B		
215	_ 3 20	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done of NOT use retired	during most of work d)	ang	Wholesa	ale Fo	ood
21		, m	12	2	Ro	ute Saleș	man		Distri	outor	
nd	be filed Ital Hygi d other event, tl	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	, Maiden Surnar	ne)	
yiaı		은	Alvin B. Binau					<u>Hawkins</u>			
			19a. Informant's Name/Relationship (Type	e. Print)		ng Address (Street			-	-	
	s 1 and 2 should Health and Mer tem 27 is marke other traumatic	l ý	Laura Marie Binau			1 Little		ourt, Ha	agerstov 20c. Location		
Ore	· -	1	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of Dispo cemetery, crei		1			•	
altimore,	t. Pa tmen tant; tant;		4 □ Donation 5 □ Other (Specify)		Cedar La						Maryland
Bai	permit. Page Department of Important: If any Injury or once.	, ,	21. Signature of Funeral Service Licenser	Munne		2. Name and Addre					and 21740
#			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line.	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician	8	Immediate Cause (Final disease or condition		1 P 5/2 C	APNIA					Onset and Death
	/Medical		resulting in death)	Due to (or as a co							
	Examiner		Sequentially list conditions, b.		1 POTIC	RESPIRA	10127	FAIL	IRE		
	pe tis	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a co		LMONIA					
	and and I-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):				<del>.</del>		
9	cate be executed physician and the burial-transit			PI	LEUROR	- FFF	noion				
68760,	phy phy the	edical	d.								
Box	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome pf p		<b>1</b>			23d. Da	ate of delive	ery
-	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□ 4□Pregnant at tim		□Ectopic pregnance □ Other <i>(specify)</i>	y 		М	lonth	Day Year
P.0	at the de by the a tached	hys	9 Unknown	9□ Unknown							
	es tha igned l	by P	Part II. Other significant conditions cont								he cause of death?
ord	w require been sig should b		ATELECTAS	70 21	RTIG	HT U	ING	1 🗆	Yes 2∐No	3 ∐ Prob	bably 4 □Unknown
Records,	law ra as be 2 sho	Completed	STROKE					24a. Was	an 24b.	Were auto	opsy findings available ompletion of cause of
<u> </u>		)om	DIABETE	s MERL	Lugi.			perfo 1∐ Yes	ormed? 2 No	death?	2 □ No
Vital	Physician: The this certificate ral director, page	Be (	25. Was case referred to medical examiner?			Lou	26. Place of Dea	th (Check only	one)		
or \	Physi this cral dire	P	1 1 tes 2 140	28a. Date of Injury	2 ER/Outpatier		4 LI Nursing H		idence 6 □Ot		fy)
п	ding F	inoi	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	(Month, Day Ye		Wor	rk? Yes 2∐No	200. Describe	how injury occu	ned	
Sign	ten eath tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury	At home farm str		162 Z [ NO	28f Location /	Street and Num	her or Run	al Route Number,
Division	al or Attendate after death	Certification:	4 ☐ Homicide determined	building, etc. (	Specify)	,,,		City or To	wn, State)		
	<b>To the Hospital or At</b> within 24 hours after d <b>To the Funeral Direc</b> completely filled in by	Medical C		ician: To the best of mer: On the basis of ex and manner stated	amination and/or in						
	o the	Med	29b. Signature and title of certifier	and manner stated		29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
	,-		Anne			Do	062001	6	11/11	6107	
			30. Name and address of person who con		n (Item 23a) (Type,					· ·	
ک	H-2		DANID ALTA	6- WIR		251	E. ANT	ETAM	1 27. 6	tAn6	MUSTEN MADERIA
	Sta Regist		31. Date filed (Month OV Year) 9 20	32. Figistrar's	Signature	locales.					,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Jerrol Moss Boyer 9:33 9. /Medical November 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Under 1 Year If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours Min. **Director** 529-38-4020 79 March 18, 1928 Utah Usual Residence of Decedent the Maryland 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 1 Yes 2 No Director Virginia Virginia Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or ms 23a must b 1680 Delaney Street 23464 Funeral USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <sub>Specif</sub>White Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates er than "natur , the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Smaller Properties Hotel Association 17 Is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Selvoy Jarrett Boyer Mary Gladys Sessions မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Rae Boyer/Wife 1680 Delaney Street, Virginia Beach, VA 23464 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important; If Ite any injury or ot once, 1 Burial 2 □ Cremation 3 Removal from State Nov. 13, 4 ☐ Donation \_5 ☐ Other (Specify) Woodlawn 2007 | Virginia Reach, VA Memorial Gardens 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ise on each line. Immediate Cause (Final colitis **Physician** Ischemic resulting in death) /Medical bowel disease Due to (or as a consequence of): Examiner 1amary Se wentially list conditions. Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exam Due to (or as a consequence of) Physician/Medical as attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate 1∐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury

vision or Vital Records, P.O. Box 68760, JERROI

funeral director, page 2 o the Hospital or Attendi ithin 24 hours after death. o the Funeral Director: A filled in by To the Hospital within 24 hours a To the Funeral C

28a. Date of Injury (Month, Day Year) 1 Natural 2 Accident

5 Pending investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1 🗌 Yes

2 🗌 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tara Marchand Roque, MD 8600 Old Georgetown Road, Bethesda, MD 20814

State Registrar

Medical

31. Date filed (Month, Day, Year) 1 3 2007 NOV

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend #5 Per INF G8/3 II/28/Department of Health and Mental Hygiene
Certificate of Death
Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Barbara C. Brobeck 2007 11:40 7, November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 5. SS 77-30-0145 **Funeral** Days Months Hours 1 □ M 2 1 F 81 09/19/1926 Director <del>579-24-8296</del> Chicago, IL Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10a, State 10b. County r 28a-f show notified at 1 Yes 2 No DC Washington None 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code an "natural", or items 23a or Medical Examiner must be 20016 4921 Rockwood Parkway NW United States Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White 2 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the M College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis G. Caldwell Irene Caldwell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8 Department of Health a Important: If Item 27 is any injury or other tra once. 4921 Rockwood Pkwy. NW Washington, DC 20016
ce of Disposition (Name of Date 20c. Location - City or Town, State Jeff Brobeck / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Bunal 2 Cremation 3 ☐ Removal from State 11/10/2007 National Crematory Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fanteral Service I cens 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Paul. Enter the disease, or complications size k, or heart failure. List only one/ au Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ntracerebra **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Examine law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown څ σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division or Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No After this certificate has 1 Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No 10 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death al or Attending P s after death. il Director: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide filled in by 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed, (Month, Day, Year) 29b. Signature add/title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year) NOV 13 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			For State Of Marylan  State Registrar	•	rtificate of E			Reg. No	0007	37959
(12	Physici	an	1. Decedent's Name (First, Middle, Last)	TEV			2. Date of De Month NOV •		2007 Year	3. Time of Death 12:31 PM
	/Medic	al -	JOHN RAYFIELD BAI  4a. Facility Name (If not institution, give street and number)	LEY	4b. City, Town, or	Location of Death	NOV.		County of Death	
1	Examin		Southern Maryland Hospi		1	inton If Under 24 Hrs.	8. Date of Bir			GEORGES
	Funeral Director		215-62-6120 1XM 2□F 56	yrs.	Months Days	Hours Min.	0ct.3	y, Year)	951 Wa	place (State or Foreign ntry) Sh. DC
	rland ow		Tour olding	City, Town or Lo						10d. Inside City Limits
	e Mary <b>3a-f sh</b> tiffied	Director	MD Prince Geo		er Marlb	oro		10- 0	tizen of What Cou	Yes 2 No
	th with the 23a or 28 ust be no		10e. Street and Number 12907 Brooke Lane			0772			U.S.A.	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuba 1 ☐ Yes 21 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		14. Race - Ameri Black, White Specify: B1	, etc. a <b>c</b> k
2-0	"natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupa e kind of work done d DO NOT use retired,	ation luring most of worl )	ing	16b. k	Kind of Business/li	ndustry
72	l withir jene. r than the Me	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		Unemploy	red			None	
ng	be filectal Hyg	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle ty Mc]			
ryla	d Men marker matic	ပ	John Bailey  19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street a			_		ip Code)
Ma	alth an 27 is i		Angela Talley (Sister)	893	2 River	Island	Dr #1	01,	Savage	,MD 20763
Baltimore, Maryland 21215-0036	it. Pages 1 authent of He rtant: If item njury or other		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)  21  Signature of Funeral Service Livense	sh Mem	osition (Name of ematory or other place orial Ce	em   11/:	L6/07 NOWDEN	Sai		own, State
Ba	Depa Impo any I		George K. Intridell	// 2	46 N. Wa	shingto	on St,	Roc!	kville,	MD 20850
000	Physician		23a. Part1. Enter ne disease, or complications that caused the deshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a.	ath. Do not er	ter the mode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a conse	∍q y nce of):						
	<i>7</i> n: ±	ner	Sequentially list conditions, if any leading to the conditions, if any leading to the conditions are cause. Enter Underlying Cause (Disease or injury that initiated events	equence of):						
	xecuter and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conse	equence of):						
68760,	ificate be executed g physician and as the burial-transit	edical E	d							
P.O. Box 68	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	etal death 3	□Ectopic pregnancy				23d. Date of deli	very Day Year
S, D.	s that the ned by e detac		Part II. Other significant conditions contributing to death but not re	1	/ /	/				the cause of death?
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il Reco	Ø 5 €	Completed by	Cancer			-	24a. Wa: auto peri 1 Yes	s an opsy formed? 2 1	prior to death?	topsy findings available completion of cause of
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n or	ng Phy fter this neral d	on: To	27. Mannerof Death 1 ✓ Natural 5 ☐ Pending (Month, Day Year)	28b. Time	of 28c. Injur Wor	y at k?	28d. Describe			
Division or Vital Record	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At building, etc. (Spe	home, farm, s		Yes 2 □ No	28f. Location City or To	(Street a	and Number or Re afe)	ural Route Number,
_	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my k (Check only one) 1 Medical Examiner: On the basis of exam and manner stated.	nowledge, dea	ath occurred at the til investigation, in my o	me, date and plac opinion, death occ	l e, and due to th urred at the time	e cause e, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	To the within 2 To the comple	Med	20h Signature and title of cartifier		29c. Licens			29d. D	Date signed (Mont	h, Day, Year)
	1		1		Doc	11001	l		11-60	61
			30. Name and address of person who completed cause of death (III  Michael Frasier MD 7  31. Date filed (Month, Day, Year)  32. Restrar's Signature of the state o	1503 S	Surrati	ESRD	. Clin	ton	mal	20735
	St Regist	ate rar	31. Date filed (Month, Day, Year)  NOV 1 3 2007	, K	Sparke					

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To the Hospital within 24 hours a To the Funeral C Hospital

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28a-f show must be notified at

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permit, Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other any injury or other traumeth

other

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72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

of Vital Records, P.O.

Division

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if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 □ Yes 2 □ No

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

2 Accident

3 T Suicide

29a. Certifier

4 Homicide

29c. License number 0046020 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYED I. ALI, MD

State

10

**6** 2007

5 ☐ Pending

investigation

determined

6 ☐ Could not be

505 DUTCHMANS LN. EASTON, MD 21601 Registrar's Signat

Registrar

n	1. Decedent's Name (First, Mid	iddle, La		BELL	Ce	ertificate o	T Deatl	n	2. Date of De	Day	Yea	ar 3	3796 3. Time of Deat 8:00 A	
al er	4a. Facility Name (If not institute					4b. City, Town	n, or Location	n of Death	Novembe		2007 ounty of De		0:00 A	
44	Alice Byrd Ta						risfie				omers	et		
	219−12−5711 1□ M 2☑ F 87 Yrs. Months Days Hours Min. (Month, Day, Year) Usual Residence of Decedent											Country)	e (State or For vland	
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Director		omer	set	C	risfi					1 🖳 Y				
2	10e. Street and Number 192 Somers Cov	70 A	nartmen	ıt a		10f. Zip Code	e 21817			10g. Citizer			?	
runesal	11. Marital Status	S. 13	. Was Decedent o		Origin? (Spe	cify Yes or No	- 14.	U.S.A.						
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ב ב	17. Father's Name (First, Midd.) James Isaac L								(First, Middle) mma Ev		irname)			
2	19a. Informant's Name/Relatio				19b. Mai	ling Address (Stre					own, State	e. Zip Co	de)	
	Tina Marie Ev	ans	(Grandda	aughter)		2 Somers							817	
	20a. Method of Disposition  1 🔀 Burial 2 □ Cremation  4 □ Donation 5 □ Other			State	lace of Disc emetery, cr	position (Name of ematory or other p e Memorial	olace)		ate	20c. Locat	tion - City	or Town,		
	21. Signature of Pureral Service	• •		2		22. Name and Ado			1 11			<u> </u>		
	Robert H. Bradshaw, Jr. 306 W. Main St Crisfield, MD 218]											817		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Ap Int	proximate erval Betweenset and Dea			
Immediate Cause (Final disease or condition resulting in death)														
Due to (or as a consequence of):														
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101111111111111111111111111111111111111	Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last	{	c		uence of):	CVD	•							
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	resulting in death) Last	{	c		uence of):	CVD	•							
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Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) Day **Physician** 2007  $A^{M}$ Herrel Jeremiah Benjamin Nov. 13 9:41 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rising Sun
If Under 1 Year If Under 24 Hrs. 607 Rising Sun Road Ceci1 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)
Sept. 25, 1927 Pennsylvania Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Months Days Hours 1 X M 2 □ F Director 217-20-0464 80 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 Rising Sun Road 21911 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Maritai Status Black, White, etc. 1 X Yes 2 ∑ No If Yes, Give Year or Dates: Tw 1 ☐ Never Married 2 ☐ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Ś 3 X Widowed 4 ☐ Divorced Specify WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: if item 27 is marked other than any Injury or other transment. Elementary/Secondary (0-12) College (1-4or 5+) 12 Grocery Store Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Benjamin Sevilla Curry ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Lovelace/Daughter 573 Rising Sun Road, Rising Sun, MD 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Nottingham Cem. 11-17-2007 Colora, Maryland R. T. Foard Funeral Home, P.A. 21 Signature of Funeral Service Licenses 111 S. Queen Street, Rising Sun, MD 21911 whara 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lige. Approximate Interval Between Onset and Death 40cardial Immediate Cause (Final **Physician** SKYTOUVS disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran: Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a, Was an autonsy 25 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 inpatient 2 ER/Outpatient 3 DDA Certification: To 5 Aesidence 6 □Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury After (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 33642 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 75441cKau 54/VA 32. Registrar's Signature State 5 Registrar

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State Registra

FLEURY

NOV 0 6 2007

31. Date filed (Month, Day, Year)

305 TENTH ST

21851

State of Maryland / Department of Health and Mental Hygiene Reg. Ng2 [] [] 7 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 22, 2007 **Physician** MEREDITH WILLIAM COLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 216-60-9038 49 12-14-1957 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 Funeral 223 West Patrick Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 🎾 No Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Work 12 Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roberta D. Cole Meredith William Cole Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South Jefferson St. Frederick , MD 21701

Date | 20c. Location - City or Town, State Roberta D. Cole Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Smithsburg Crematory 11/24/2007 Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Licensee M01176 106 East Church Street Frederick, MD 21701 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final denocarcinoma Physician months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the attending physician and hed for use as the burial-tran Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No tal or Attending Physician: Tis after death.

al Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 2 ☐ ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41866 November 23, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan Hudhud, MD 5 Drive /homas Johnson Fredenck. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	1	State Amend #8 Per F	H G874"12/17/0	Department of Health and Certificate of Death		
Physicia	_	1. Decedent's Name (First, Middle, Last)	B. C1e	ementson	2. Date of Death Month November	ay Year 7:00 A
/Medica	al _	Eleanor  4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Dea		c. County of Death
Examine		Southern Maryland H	lospital	Clinton	2 O Date of Birth 1	Prince George's
Funeral Director		5. Social Security Number 6. Sex 1 □ M	7. Age (In yrs. last bi	irthday) If Under 1 Year If Under 24 Hr Yrs. Months Days Hours Mir	Administra Character Manager	931 9. Birthplace (State or Forei Country) Pennsylvania
70		Usual Residence of Decedent	10c City Toy	vn or Location		10d. Inside City Limi
Marylar f show led at	ō	10a. State 10b. County  Maryland Prince Geor		e Hills		1 □ Yes 2 <b>½</b> ¾
or 28a-	irect	10e. Street and Number		10f. Zip Code		Citizen of What Country?
ath wil	ral	4109 24th Place	Was Doodont Ever in LLS	20748		JSA 14. Race - American Indian,
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ⚠ Married  3 □ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue  1 □ Yes 2XXNo Specify:	erto Rican, etc.)	Black, White, etc.  Specify: White
72 hou	eted	15. Decedent's Educat (Specify only highest grade of		a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking 16b.	Kind of Business/Industry
within iene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Bookkeeping		Private Industry
ld be filed ental Hygi ked other ic event, t	To Be Co	17. Father's Name (First, Middle, Last) Frank Milienewicz		18. Mother's N	<sub>ame (First, Middle, Maid</sub> Stacharek	en Surname)
2 should and Men Is marke		19a. Informant's Name/Relationship (Type.		b. Mailing Address (Street and Number or		
1 and Health 9m 27 ther tr	-	Lewis E. Clementson /		4109 24th Place Temple of Disposition (Name of tery, crematory or other place)		Location - City or Town, State
Pages nent of H int: If ite		t Surial 2 ☐ Cremation 3 ☐ Ren	noval from state Marylan	d Vet. Cemetery 11/	14/2007 Ch	eltenham, Maryland
permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licensee	é h	22. Name and Address of Facility (6160 Oxon Hill Road 0	0	
Physician / Medical Examiner putsician and physician and sthe prival-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e city	£	Önset and Deat
death certif e attending d for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ YMo 9 □ Unknown	:. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□Unknown			23d. Date of delivery Month Day Year
requires that the een signed by the	y Ph	Part II. Other significant conditions contr	ibuting to death but not resulting	g in the underlying cause given in Part I.		co use contribute to the cause of death 2 □ No 3 ☑ Probably 4 □ Unkn
require een sig	ted	le pleman il	Hirron -		_	
The lar ate has page 2	Comple	Sihus Mich	faraici_		24a. Was an autopsy performed 1☐ Yes 2☐	
Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ 対  Ho	spital: 1 Inpatient 2 ER/	Other:	Death <i>(Check only one)</i> g Home 5 ☐ Residence	e 6 □Other (Specify)
		27. Manner of Death		p. Time of 28c. Injury at Work?	28d. Describe how i	
or Attendition death	Certification:	1 XX Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, tate)
To the Hospital within 24 hours a To the Funeral Completely filled	Medical Co	29a. Certifier  (Check only one)  29a. Certifying Physical Control only 2 Medical Examine	cian: To the best of my knowled er: On the basis of examination and manner stated.	dge, death occurred at the time, date and p and/or investigation, in my opinion, death o	lace, and due to the caus occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the To the To the Compl	Me	29b. Signature and title of certifier	- 1	29c. License number		Date signed (Month, Day, Year)
		I Vagoba Ua	misson in	D 0064289	No	vember 8, 2007
		00007700	7 - 7 55 - 7			
(6)		30. Name and address of person who con	npleted cause of death (Item 23	a) (Type, Print) 7503 Surratts Road, Cli	nton. Marvland	. 20735

	4-	_ 1	For State Registrer		State	of Ma	ryland	d / Depa <i>Cer</i>	artmei <i>tifica</i>	nt of H te of L	ealth a Death	ınd M	F	Reg. No.	2007	37	966
Phys	sicia	-	Decedent's Nam	ne (First, Middle	Joseph	Lim	nod (	Chaney					2. Date of Dea Month Novemb	Day	Year		e of Death 22 P M
/Me	edica mine	1	4a. Facility Name	If not institution	n, give street and r		con c	aidiey	4b. City	, Town, or	Location o	f Death	Novemb		County of Deat		22 P
			Holy Cr								Sprin	_			Montg		
Funei Direct	_		5. Social Security   None		6. Sex 1 📆 M 2 🗆 F	_	(In yrs. la	ast birthday) Yrs.	Months	Days	If Under 2 Hours	Min. 30	8. Date of Birt (Month, Day NOV. 6,	h 2007	9. Birt Co Mar	hplace (Sta untry) yland	te or Foreign
rland ow		- I	Usual Residence of 10a. State	10b. County			10c. City	, Town or Lo	cation	<u></u>						10d. Inside	e City Limits
a-feh		ğ	aryland (	Prince (	George		Upper	r Marlbo	oro							101	res 2 No
3s or 28		Dire	10e. Street and Nu 3108 Eton			-			10f. Z	p Code 2077	2			_	izen of What Co SA	untry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment: If item 27 ie marked other then "natural", or iteme 23e or 28e-f ehow any fulury or other treumatic event, the Medical Examinar must be notified at		by Fur	11. Marital Status 1 🐼 Never Mar 3 □ Widowed	ried 2 Mari		Forces? s 2 ⊠ N Give			Was Deck f Yes, spi 1 ☐ Yes	ecify Cuba	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit Specify: Wh	e, etc.	η,
within 72 ho ene. then "natur		Completed	(Spe	cify only highe	t's Education st grade complete College	d) (1-4or 5-	+)		dent's Usi kind of w DO NOT I	ual Occupa ork done d use retired	ation furing most	of workii	ng		ind of Busi <i>ness</i>	Industry	
e filed al Hygi other		9	17. Father's Name								18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
y car		2	Sean Brow										Inn Caro				
id 2 sh lith and 27 ie rr	1	1	19a. Informant's N Sean B. Ch						_				i Route Numbe oro, Md.		or Town, State, 2 2	(ip Code)	
ages 1 arent of Heal		İ			3 ☐Removal fro	m State	CE	lace of Dispo emetery, crer as Crema	sition (Na	me of	θ)		ate	20c. L	ocation - City or water, Mai		•
permit. Pages Department of Important: If I	Suce		21. Signature			,		22	. Name a				orge P.	Ka1	as Fune , Maryl	ral H	ome PA 20745
			23a. Part 1. Enter shock, or he	the disease, or art failure. List	complications that	t caused reach lin	the death									Approxi	Between
Physicia /Medic			Immediate Cause disease or conditi resulting in death	on	a		XTRE	ME PRE	MATU	RITY						Onsera	nd Death
Examin			Sequentially list c	onditions.	b	В	ICOR	NATE U	TERU	S							
cate be executed physicien and sthe burial-transit		dical Examiner	Sequentially list c if any, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)	rinjury ts	<b>S</b> c		a consequ										
		თ ⊢			d												
Physician: The law requires that the death certificate has been signed by the ettending rail director, page 2 should be detached for use as		Physician/M	IF FEMALE: 23b. Was decede in the past 1: 1  Yes 2 9  Unknow	2 months?		e birth ignant at	of pregnar 2  Fetal time of de	death 3	Ectopic   Other (s	oregnancy specify)					23d. Date of de Month	ivery Day	Year
luires that the signed by lid be detailed.		ا م	Part II. Other sign	ificant conditi	ons contributing to	death bu	it not resu	ulting in the u	nderlying	cause giv	en in Part I.				use contribute to		
The faw require the has been single bade 2 should		Completed											24a. Was autor perfo	med?	24b. Were au prior to death?	utopsy findicompletion	ngs available of cause of
clan: ertifice		Be	25. Was case refe examiner?	erred to medica								of Death	(Check only o				
Physi r this c		2	1 Tes 218			XInpaties te of Injur onth, Day		ER/Outpatier		28c. Injun	4 🗀 140		ne 5 ☐ Resid 28d. Describe I		6 ☐Other (Spe	cify)	
ath. or: Afte		atlor	1 <b>EN</b> atural 2 ☐ Accident	5 Pendir investi	gation	onth, Day	Year)	Injury	м		k? Yes 2 ⊡i	No					
tal or Atta		Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could detern	nined   206. Pic	ice of Inju	iry - At ho . (Specify	me, farm, str	eet, facto	ry, office		1	28f. Location (: City or To		nd Number or R. e)	ural Route i	Vumber,
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, sage 2:		edical	29a. Certifier (Check only one)	XXCertifyii 2 ☐ Medical	ng Physicien: To Exeminer: On the and m	the best of basis of anner sta	examinat	wledge, deat tion and/or in	h occurre vestigatio	d at the tin	ne, date an pinion, dea	d place, a	ed at the time,	date an	d place, and due	to the cau	
To 1		Σ	29b. Signaturi an	d title of certifie	HOO.	lf	91		2:	ec. Licens	D 377	07			ember 7,		ar)
1					who completed co					#505	D = -1	1 1	- M	. 1	1 2005	0	
	Stat	e_	31. Date filed (Mo	Glass					LIKE	# <b>3</b> U5	KOCK	CVILL	e, Mar	y⊥an	d 2085	۷	
	istra		NOV 1	3 2007	heran 32	1.	Do	was									

			For State Registrar	State of	of Marylan	-	ertment of H		and M		giene Reg. No. ()	2007	27067
<b>9</b> -	Y 7	-01	Decedent's Name (First, Middentification)	lle, Last)						2. Date of De		Year	3. Time of Death
	Physicia /Medic		Clare	C	ampbell_					11	4	2007	11:07 M
	Examin	100000	4a. Facility Name (If not institution	on, give street and nu	mber)		4b. City, Town, or	Location o	f Death			ounty of Death	
			10300 Garson				Lanham If Under 1 Year	If I Inday	04 Uro	0 Data - ( D)		ince George's	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 21X F	7. Age (In yrs. I	ast birthday) Yrs.	Months Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da NOV 10	n y, Year) 103	9. Birthi Cou	place (State or Foreign ntry) aica
	Director		218-33-6030 Usual Residence of Decedent		75					NOV I	J 195.	Jan	arca
	/land ow at		10a. State 10b. Count	у	10c. City	, Town or Lo	cation						10d. Inside City Limits
	Many a-f sh fied	ţċ	MD Prine	ce George'	s	Lanham							1 TyYes 2 □ No
	or 28%	irec	10e. Street and Number	8-			10f. Zip Code					n of What Cou	ntry?
	th will	al [	10300 Garson	Terrace			20706					USA	
	r dea	Funeral Director	11. Marital Status	Armed F		S. 13.	Nas Decedent of Hi f Yes, specify Cuba	Ispanic Orig In, Mexican	gin? (Spo 1, Puerto	ecify Yes or No Rican, etc.)	- 14	Race - Ameri Black, White,	
36	s afte ; or if	by Fi	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes, G	2⊈ No ive		1 □ Yes 2√□ No	Specify:			S	Specify: B1	ack
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show whit, the Medical Examiner must be notified at	q pe		nt's Education	Jaies.	16a. Dece	dent's Usual Occupa	ation			16b. Kind	l of Business/Ir	ndustry
5	in 72 "na" r	olete	(Specify only high	est grade completed,		i (Give	kind of work done o	durina mosi	t of work	ing			
212	with jiene. r thar the N	Completed	Elementary/Secondary (0-12) 10th	College	(1-4or 5+)	Но	me Maker				Pri	vate	
	al Hyg other /ent,	Be C	17. Father's Name (First, Middle	e, Last)						e (First, Middle	Maiden S	urname)	
lar	uld be Jenta rked tic ev	TO E	Jermiah J. Ta	ylor				Zipo	rah	Smith			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relation Sandra Henry/				ng Address <i>(Street a</i> Garson Te						
Baltimore,	ges 1 and 2 it of Health If Item 27 i		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo emetery, crea	sition (Name of matory or other place	1		Date		ation - City or T	
ij	t. Pa rtmen rtant; njury		4 □ Donation 5 □ Other (		Ha		Cemetery		11/1	0/2007	Land	over, Ma	ryland cal Home
Bal	permit. Pages : Department of H Important: If Ite any Injury or of once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. 7474 Landover Road L.											
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a.	RESPIR	LATOR	Y FAIL	URE	•				24 HRS
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):	Y FAIL	۰		C 2 2 2-	2.0		3 months
1	i i i i i i i i i i i i i i i i i i i	<b>1</b>	Sequentially list conditions,	b. Due to	(or as a conseq	uence of:	IC L	1761	AL	SILE	12051	5	5 monus
	ted nsit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	(								
,	execunate and al-tra	Exal	that initiated events resulting in death) Last	C	(or as a conseq	uence of):							
8760,	ate be executed oblysician and the burial-transit	g		d									
ø	tificati g phy as the	edi										=	
Box	h cert	Physician/Medical	IF FEMALE:   23b. Was decedent pregnant		utcome pf pregna		⊒Ectopic pregnancy	ı			23	d. Date of deliv	,
	deat le atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of c		Other (specify)					Month	Day Year
P.0	at the by th	hys	9 Unknown							00 - 5:4			Also aguas of death?
Records, I	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by F	Part II. Other significant condi								obacco us Yes 2⊠		the cause of death? bably 4 □Unknown
Ö		lete	DYSARTHRI	A DYS	PHAGIA					24a. Was		24b. Were au	opsy findings available
Re	The la	I I		, - 2						auto perfe 1⊟ Yes	psy ormed? 22 No	prior to c death? 1 ☐ Yes	ompletion of cause of 2⊠ No
tal		Be C	25. Was case referred to medic	cal				26. Place	e of Deat	th Check onl		1 🗆 103	2,5110
>	Physician: r this certifica ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4□ Ni	ursing Ho	ome 5 <b>™</b> Res	idence 6	□Other (Spec	rify)
0	ng Ph ter th neral	i.i	27. Manner of Death	18.80	e of Injury onth, Day Year)	28b. Time o	of 28c. Injur Wor	y at k?		28d. Describe	how injury	occurred	
Ö	Attending r death. ector: After by the fune	atio	Z LI Accident	stigation			M 1□	Yes 2 ☐	No				
Division or Vital	or Atter de Directo	rtific	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	minod   20e, Flat	ce of injury - At he ding, etc. <i>(Specia</i>	ome, farm, st fy)	reet, factory, office				Street and wn, State)	Number or Ru	ral Route Number,
	spital ones al	ပိ	200 Cartifier 1 1 Cartifi	/ing Physician: To ti	as boot of my kny	wledge des	th occurred at the ti	ma data a	nd place	and due to the	(2)(ea/e)	and manner as	stated
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director, After this: completely filled in by the funeral director.	Medical Certification:		al Examiner: On the									
	To the vithil To the comp	Me	29b. Signature and title of certif	1	0		29c. Licens		22			signed (Month	
			> Lhishan	why "			= 000	335	03		1 /	- 5 - 0	<i>r</i>
12	- (2)		30. Name and address of person	on who completed ca	use of death (Iter	n 23a) (Type, Annap	Print) olis Rd #	301	Lan	ham,Mar	yland	20706	and the second
	St. Regist	ate rar	31. Date filed (Month, Day, Yea NOV 1 3 2007	ar) a2.	Registrar's Sign								

DHMH 17 Rev 1/2001

			For Stata Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of H			ene g. 200	)7	37968
		¥	Decedent's Name (First, Middle, L.	ast)				2. Date of Death		Year	3. Time of Death
	Physici /Medic		Candace Lee Coch	nran				Nov.		007	10:30 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution, g		ar)		Location of Deat	h	4c. County	_	
39"			13616 Rockcliff  5. Social Security Number 6.		Age (In yrs. last birthday	Hagerst	OWN If Under 24 Hrs	8. Date of Birth	Was	hing	
	Funeral Director		212-62-3337	1 M 2 XF	53 Yrs.	Months Days	Hours Min.	07/16/1	<sub>Year)</sub> 954	Cour	place (State or Foreign ntry)  MD
	ס		Usual Residence of Decedent					0771071			
	arylar ehow	<u>.</u>	10a. State 10b. County		10c. City, Town or t					1	10d. Inside City Limits 1 ☐ Yes 2 X No
	he M	Director	MD Washir	igron	Hagers	10f. Zip Code		11	Og. Citizen of V	Mhat Cou	
	hours after death with the Maryland tural', or Items 23a or 28e-1 ehow al Examinational be notified at	ā	13616 Rockcliff	Drive		21742			US	THE COU	tuy:
	ms 23	Funeral	11. Marital Status	12. Was Decede		. Was Decedent of H	ispanic Origin? (S	pecify Yes or No-			can Indian,
9	or ite	Fur	1 Never Married 2 Married	1 Tes 2		If Yes, specify Cuba 1 ☐ Yes 2 No	in, Mexican, Puer Specify:	to Hican, etc.)	Specify	k, White,	etc. ite
933	ural',	d by	3 ☐ Widowed 4 X Divorced	Year or Date							
15-	within 72 h ene. than "nati	Completed	15. Decedent's (Specify only highest g		16a. Dec (Giv life.	edent's Usual Occup e <i>kind of work done d</i> DO NOT use retired	ation during most of wo f)	rking	16b. Kind of Bu	isiness/In	dustry
212	withi	mo du	Elementary/Secondary (0-12)	College (1-4d	or 5+) !	ruck Driv			Tru	ckin	g
פ	be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or items 23s or 28e-1 show event, the Medical Examiner man be notified at	BeC	17. Father's Name (First, Middle, Las	st)			18. Mother's Nar	me (First, Middle, M	Maiden Surnam	10)	
ylaı	2 should be fit and Mental H is marked out aumatic ever	으	Delmas Monroe So	chroyer			Glor	ia Ernest	ine Sw	anso	n
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship  Jaysen A. Cochra			ing Address (Street a			-		
ത്	item 27 i		20a. Method of Disposition	/		osition (Name of ematory or other place			20c. Location -		
Baltimore,	permit. Pages. Department of I Important: If ite eny injury or ot		1 Ma Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Resthave	en Mem. Gd	ns. 11/1	.7/2007 <sub>I</sub>	rederi	ck.	MD
alti	permit. Departm Importa eny inju	- 1	21. Signature of Funeral Service Lic	envee 🔾		22. Name and Addres	ss of Facility Ge	rald N. N	Minnich	Fun	eral Home
<u> </u>	8 G E E 8		107			805 N. Pot	omac Str	eet, Hage	erstown	, MD	21740
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus y one cause on each	sed the death. Do not en i line.	nter the mode of dyin	g, such as cardia	c or respiratory arre	est,		Approximate Interval Between Onset and Death
- X	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Da	ncreatic	Lance	1				
	Examiner		1	Dufe to (or	as a consequence of):						
	Jan.	er	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury	b. Ewe to (ur	as a consequence of):		-				
	cuted od ransit	Examiner	that initiated events	С.							
0,	e exe cian a urial-t	EX	resulting in death) Last	Due to (or	as a consequence of):						
8760,	that the death certificate be executed ed by the attending physician and detached for use as the bunal-transit	dical		d.							
9 x c	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregnancy				23d Dat	te of delive	erv
Box.	death e atter d for u	Physician/M	in the past 12 months?	4□Pregnan	at time of death 5	□Ectopic pregnancy □ Other (specify) _			1	nth	Day Year
P.0	at the de by the stached	hys	9 Unknown	9□ Unknowr	1						
	8 C 90	Ď	Part II. Other significant conditions	contributing to deat	n but not resulting in the	underlying cause give	en in Part I.		-		he cause of death?
Vital Records,	w requires been sign should be	ompieted						1 🗆 Ye			oably 4 □Unknown
<b>3ec</b>	2 2	mpi						24a. Was ar autopsy perform	/	Were auto prior to co death?	opsy findings available empletion of cause of
a		e Co	25. Was case referred to medicat				Pl	1 ☐ Yes 🥞	No	Yes	2□ No
	Physician: this certific ral director,	0 0	examiner?	Hospital:	atient 2 ER/Outpatie	ent 3 DOA Oth	0.5	ath <i>(Check only one</i> dome Reside		er (Speci	fv)
100		T:uc	27. Manner of Death	28a. Date of I (Month,			y at	28d. Describe ho			77
Siol	Attending r death. ector: After by the fune	catic	2 ☐ Accident investigat	on	,		Yes 2□No				
Division of	spital or Attend ours after death heral Director: / filled in by the f	Certification;	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of	Injury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Str City or Town	eet and Numb , State)	er or Rura	al Route Number,
	pite ours seral		29a. Certifier Certifying	hvsician: To the be	st of my knowledge, dea	th occurred at the tin	ne date and place	and due to the ca	use(s) and ma	inner as s	stated
	within 24 hose To the Fur	Medical	(Check only 2 Medical Ex one)	aminer: On the basis	s of examination and/or i	nvestigation, in my o	pinion, death occi	urred at the time, da	ite and place,	and due to	o the cause(s)
	To the To the complet	Σ	29b. Signature and title of certifier			29c. Licens			d. Date signe		Day, Year)
· C	4D					D	4844	0	11/1-	t /d	00
	8			SENA, M	D 13424	Pennsyl	Varia A	lve Ha	egerst	ron	ND 21740
No.	Sta Registr		31. Date filed (Month, Day, Year)	2007 32. R	strar's Signature	tooks.			•		

			1 - For State Registrar	State of	Marylar	nd / Depa	artment rtificate	t of H e of L	lealth a Death	and M		giene Reg. No.	/         /	37	969
ę/c	Physici	ian	1. Decedent's Name (First, Middle, Las	·							2. Date of De Month	-		3. Time o	of Death
	/Medic			Cokenias							Novemb	er 8	, 2007	5:15	a <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give Holy Cross Hospi		er)				Location			40.	County of Death		
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th Year)	9. Birth	place (State	or Foreign
ľ	Director		5/9-18-2/59	□M 21K□F	86	Yrs.	Months	Days	Hours	Min.	July 3			intry) ingtor	n, DC
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside C	ity Limits
	Maryl -f sho fied a	ţō	Maryland Mor	tgomery		Si	lver S	Snri	na						2 <b>X</b> XIO
	th the	Director	10e. Street and Number				10f. Zip		.19			10g. Citi	zen of What Cou	ntry?	
	23a cust bust bust bust bust bust bust bust b		1605 Imperial	Drive					902				USA		
	hours after death with the Maryland tural", or Items 23a or 28a-f show at Examiner must be notified at	Funeral	11. Marital Status	12. Was Decede Armed Force 1 ☐ Yes 2	es?	.S. 13.	Was Deced If Yes, spec	lent of Hi afy Cuba	spanic Origin, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	-	<ol> <li>Race - Ameri Black, White</li> </ol>		
336	urs aff	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2	No.	Specify:				SpecifyWhit	.e	
15-0036	72 hou natura Ilcal E	ted	15. Decedent's Ed (Specify only highest gra	ucation		16a. Dece	dent's Usua	l Occupa	ation	t of worki	na	16b. Ki	nd of Business/I	ndustry	
2	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of word DO NOT use		)	COI WOIKI	ng				
7	filed w Hygie ther th	S	17. Father's Name (First, Middle, Last)	2		Ho	omemak	cer	18. Mothe	r's Name	(First, Middle		Own Home	<u> </u>	
an	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show unatic event, the Medical Examiner must be notified at	To Be	Thomas Glakas								anis	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ourname)		
Maryland 2		F/	19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	al Route Numb	er, City o	r Town, State, Zi	p Code)	
	and 2 ealth a n 27 is	L y	Nicholas T. Coken	ias/Husk		1605	Imper	rial	Driv	e, S	ilver ;	Sprin	ng, MD 2	0902	
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from Sta		Place of Dispo cemetery, crea				Nov.	<sup>Date</sup> 13,	20c. Lo	cation - City or T	own, State	
Baltimore,	it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Gat	e of He	eaven				007	Silve	er Sprin	g, Mar	yland
g	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	relate	_	F	rancis	зJ.	Coll	ins	Funeral	l Hon ilveı	me Inc. Spring	, MD 2	20901
			23a. Part1, Enter the disease, or compositions, or heart failure. List only	olications that cal one cause on eac	ed the deat h line.	th. Do not ent	er the mode	e of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approxima Interval Be Onset and	tween
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			REBRA	1	BU	ED					HOUR	S
	Examiner			Due to (or	as a conseq	juence of):	ropy	1	THEP	LOK				YEAR	C
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a conseq	uence of):	CH		2000	156				/ ()/(1=	
7	ecuted ind transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c											
8/60,	certificate be executed Iding physician and Ise as the burial-transit	al E	rosaning in doutily East	Due to (or	as a conseq	juence of):									
2	ficate physis the	edical		.d											
ROX	w requires that the death certific been signed by the attending p should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			7=-4:					2	23d. Date of deliv	ery/	
ם כ	ed for u	sicia	in the past 12 months? 1 ☐ Yes 2 🔼 No		h 2∐Feta nt at time of c n		Ectopic pre Other (spe						Month	Day	Year
<u>.</u>	nat the d by t letach	Phy	9 ☐ Unknown  Part II. Other significant conditions or			ulting in the u	adorlying oa	ueo civo	n in Dart I		22a Did t	obacco u	se contribute to	the source of	doath?
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cord	law requas been 2 shoul	Completed									24a. Was	an	24b. Were aut		
Ž	The la	dmo									autoj perfo	psy rmed?	prior to co	ompletion of	cause of
		0	25. Was case referred to medical examiner?						26. Place	of Death	1□ Yes (Check only o		1 □Yes	2 2 No	
_	<u>~</u> .≃ ∪	To B	1 ☐ Yes 2 No			ER/Outpatien	t 3 🗆 DO	A Othe	er: 4 🗆 Nu	rsing Ho	me 5□Resi	dence (	6 □Other (Spec	ify)	
0 0	ing P		27. Manner of Peath  1 ★ Natural 5 Pending	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time of Injury		Bc. Injury Work			28d. Describe	how injur	y occurred		
VISION	Attenc death ctor: y the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of	injury - At ho	ome, farm, str	M eet. factory.		Yes 2□1		28f Location (	Street an	d Number or Rui	al Route Nu	mher
2	tal or / s after al Dire ed in b	Certification:	4 ☐ Homicide determined	building	, etc. (Specif	fy)	,				City or To			ar riodio i va	77201,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (	29a. Certifier 1 CertifyIng Physics (Check only one) 2 Medical Example 1	/sician: To the be ilner: On the basi and manner	is of examina	wledge, deatl	occurred a	at the tim in my o	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause	(s)
	To th within To th compl	Me	29b. Signature and title of certifier	4			29c.	License	number			29d. Dat	e signed (Month	, Day, Year)	
)	20		> Vulwamade	tya.D.	Red	dy MD		D43	3464			NOV	EMBER -	08-20	107
			30. Name and address of person who	•	of death (Iten	n 23a) (Type,	Print)	4		مر		ROL	e signed (Month EMBER – KULLE ) – LOS	~~	
		10	VILLAM ADITYA D . S 31. Date filed (Month, Day, Year)		istrar's Signa	ature	KVILL	EP	lice	704	E 108	, MI	5- 108	12	
	Sta Registr	100	NOV 1 3 20	100	Present A	K So	anti)								

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		Registrar  1. Decedent's Name (First, Middle, Last)				rimeate	O Death		2. Date of Death	g. No.		3. Time o	of Death
Physicia	an	•							Month	Day	Year		
/Medic			on COHEN_			Ab City T	own, or Location	n al Daath	November	4c. Count		1:25	A
Examin	er	4a. Facility Name (If not institution, give s				,	1				•		
		Alfred House Assis	sted Livin	lg //a um	last birthda		ckville Year   If Und		8. Date of Birth	Mon	tgome	olace (State	or Foreign
Funeral		5. Social Security Number 6. Sex	M 2□F		Yrs.		Days Hours		(Month, Day,		Coul	ntry)	
Director		578-20-0871 Usual Residence of Decedent		87					Dec. 4,	1919	Wasii	ingtor	I, DC
land ow		10a. State 10b. County		10c. Cit	y, Town or	Location						10d. Inside C	City Limits
Mary Heah	ţō	Maryland Montgome	ery	C	hevy	Chase						1 🗌 Yes	2 🔀 No
with the Maryland a or 28a-f ahow be routiled at	Director	10e. Street and Number				10f. Zip 0	Code		10	g. Citizen of	What Cou	ntry?	
23a o	0	8101 Connecticut Av	renue #C30	17		20	0815		1	United	Stat	es	
daath	Funeral		2. Was Decedent Ev		.S. 13			Origin? (Sp	ecify Yes or No- Rican, etc.)			can Indian,	
after das or items miner m	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐¥es 2 ☐ No	Nav	v				Hican, etc.)		ick, White,		
Pari, c	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WW	-	1 □ Yes 25	No Specia	ry.		Specii	fy: whi	Le	
within 72 hours after daath with the Maryland ane. than "natural", or items 23a or 28s-f ahow to Modical Examinal must be notified at	etec	15. Decedent's Educ (Specify only highest grade			(Gir	edent's Usual	done during m	ost of work	ting 1	6b. Kind of B	lusiness/In	dustry	
ithin nen.	npie	Elementary/Secondary (0-12)	College (1-4or 5+	)	`life	. DO NOT use	retired)						
ed w ygiar yer th	Completed		5 <del>+</del>		D	entist	1			Denti			
d ott	Be	17. Father's Name (First, Middle, Last)							e (First, Middle, M	faiden Sumai	ne)		
Men Men arke	ပ္	Mayer Cohen						ssie					
2 sh and Is m		19a. Informant's Name/Relationship (Type	•			-			al Route Number,				20815
end aelth m 27		Esther Cohen -wife		201 5					#C307, 0				20015
permit. Pages 1 end 2 should be filed within 72 ho Depertment of Haelth and Mental Hygiane. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		20a. Method of Disposition  V☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	C	emetery, ci	position (Name ematory or oth	er place)	11/1	4/0/	Oc. Location			
men tant: jury		4 Donation 5 Other (Specify)		Nat					metery	Capita	l Hei	ghts,	MD
permit Depert Import any in		21. Signature of Fane al Service License	θ			22. Name and Torchir	Address of Fac skv Hel	brew	Funeral I	Home			
40 = 4 a		23a. Part1. Enter the disease, or complic		>							DC _	20012	
		23a. Part1. Enter the disease, or complic shock, or heart failure. List onty on	ations that caused t e cause on each line	he deati i.	h. Do not e	nter the mode	of dying, such	as cardiac	or respiratory arre	st,		Approxima Interval Be Onset and	tween
Physician		Immediate Cause (Final disease or condition	Hypotens	sion									
/Medical Examiner		resulting in death)	Due to (or as a		_								
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ate be executed hysicien and the burial-transit			Coronary	,		Disease	9						
	dical	d											
requires thet tha death certific een signed by the attending p hould be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of							23d. Da	ate ol deliv	erv	
atter 1 for u	ciar	in the past 12 months?	1 Live birth 2 4 Pregnant at ti			□Ectopic pre □ Other (spe					onth		Year
by the destached	ysi	9 Unknown	9□ Unknown										
res thet	y P	Part II. Other significant conditions con	tributing to death but	not res	ulting in the	undertying car	use given in Par	rt I.	23e. Did tob	acco use con	tribute to t	he cause of	death?
n sig	ă d	Dementia Alzheimer	's Type						1 🗆 Ye	s 2□No	3 🗆 Prol	bably 4 🖔	Unknown
s been sign	jete								24a. Was an		Were aut	opsy lindings	available
The la	E								autopsy perform	ed?	death?	mpletion of o	cause or
tifical	0	25. Was case relerred to medical					26. Pla	ice of Deat	h (Check only one		103	2010	
ysici s cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital:	t 2 🗆	ER/Outpati	ent 3 DOA	100		ome 5 Reside		her (Speci	(v) Assi	sted
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Atte	1	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur- building, etc.	y - At ho	ome, farm,	street, factory,	office		28f. Location (Str. City or Town,		ber or Run	al Route Nur	nber,
rs eft el Di	Certification:									,			
To the Hospital or Attending Physician: The law within 24 hours effer death.  To the Funerel Director: Affer this certificate has b completely filled in by the funeral director, paga 2 st	edicai	29a. Certifier 1 Certifying Phys (Check only one)  1 Certifying Phys 2 Medical Examin		xamina									(s)
Fo the	Me	29b. Signature and title of certifier					License numbe	r		d. Date sign		-	
10+1		29b. Signature and title of certifier  The second s	Counce	ea,	1	D	25410			Nove	nelec	13.	2007
, - , ,		30. Name and address of person who cor	npleted cause of dea	ath (Item	n 23a) (Typ	e, Print)					2000		
		Oliver Lawless, M.	D., 18111	Pri	ince F	hilip	Drive,	#202,	Olney,	MD 20	)832		

Registrar DHMH 17 Rev 1/2001

State

31. Date liled (Month, Day, Year) NOV 1 3 2007

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** William . Caludis Jr. G. November 8, 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Months Days Hours Min. 1 ☑ M 2 ☐ F 577-64-7060 DĈ Director Nov. 8, 1940 67 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1XYes 2 No Maryland Montgomery Bethesda Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20817 United States 8307 Still Spring Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Business Dry Cleaner s 1 and 2 should be filed a f Health and Mental Hygie item 27 is marked other 1 other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William G. Caludis Helen Sapourn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Caludis / Wife 8307 Still Spring Court Bethesda, MD 20817 Pages 1 an nent of Healt nt: If item 27 y or other to Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p. Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Parklawn Memorial Pk. 11/13/2007 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Apen 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** العدر roba /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760 attending physician Completed by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? or Vital Records, signe be a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? death? 1 ☐ Yes 2 ☐ No 2 XNo Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1
Yes 2□ No 2XER/Outpatient 3 □ DOA 1 🔲 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death

Natural

Control

Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division To the Hospital or Attending 5 ☐ Pending investigation ifter dea. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be within 24 hours after dear To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier,

State Registrar mo DME

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TRA ~ BRECKER MO DME

31. Date filed (Month, Day, Year) NOV 1 3 2007

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Park PI

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Shirley Cianciolo Mae 2007 0610 3 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical Center 1comico Keninsula Regional Palisburg. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 8/21/1936 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🖫 F Wisconsin 71 Director 394-34-1356 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ural", or items 23a or 28a-f show Examiner must be notified at 1 TYes 2 No Director Maryland Wicomico Hebron 10f. Zip Code 10q. Citizen of What Country? 10e. Street and Number death with 21830 USA 9131 Waxwing Court "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify white Completed by Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ambrosia Chocolate Co 12 Payroll accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Stanislawski Lillian Dulak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra 26889 Osprey Circle, Hebron, MD 21830 Rebecca Woods/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/5/07 Salisbury, MD Salisbury Crematory Signature of Funeral Service Licensee Name and Address of Facility Home Professional Association Javid H. 501 Snow Hill Rd., Salisbury, MD 21804 honopoor Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Inanition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ongestion Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed PRV+ physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 9 Unknown conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown oronary Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Impatient Certification: To within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral of 28a. Date of Injury (Month, Day 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

DHMH 17 Rev 1/2001

394-34-1356

State

29b. Signature and itle of certifier

STEVEN

Registrar

29c. License number

100 E. Carroll St., Salisbury, MD 21801

29d. Date signed (Month, Day, Year)

November 3,200

and manner stated.

32. Figistrar's S

strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TAMLE

6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day **Physician** BETTY DAVIS 11 20 07 0145 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 27, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 M 2 □ F 236-94-3409 50 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Allegany Oldtown 1 ∏Yes 2 ☐ No "natural", or items 23a or 28a-f sh cdcal Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21555 16701 Davis Hollow Rd. SE USA items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 📉 o Specify: Specify: þ 3 Widowed 4 Divorced white Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  $\underset{12}{\text{Elementary/Secondary (0-12)}}$ College (1-4or 5+) marked other than Superfos Packaging laborer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 Is marked othwany injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Voyne Smith, Sr. Margaret Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) MD 21555 husband 16701 Davis Hollow Rd. Oldtown Harry Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oliver Grove Cemetery 11/24/2007 MD Oldtown 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a, Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or heart failure. Ast only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastat DECOST **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of): Examine ending physician and use as the burial-transit The law requires that the death certificate be executed Division or Vital Records, P.O. Box  $68760, \mathscr{C}_{\mathscr{L}}$ Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No 1∐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2√ No 1 🗌 Yes 2 ER/Outpatient 3 DOA 2 1 Inpatient 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No after death.

Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital or within 24 hours a To the Funeral L completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Be

DC

**Funeral** 

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

Hospital or Attending Physician: 4 hours after death.

within 24 hours a

To the Funeral L

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. TICUTE RESPIRATOR Due to (or as a consequence of):  C. R. CTRAIN TECTIMIAL RI	
that initiated events resulting in death) Last	c. GASTROINTESTINAL BL Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery Month Day Year
 Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably ※XXUnknown
		24a. Was an autopsy performed?  1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical examiner?	26. Place of Death	Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of 28c. Injury at Work?  Injury M 1 Tyes 2 No	ld. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 ♣ CertifyIng Ph (Check only one) 2 ☐ Medical Exar	ysician: To the best of my knowledge, death occurred at the time, date and place, an inner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated.  If at the time, date and place, and due to the cause(s)

MD 52855

State

Registrar

NOV 1 3 2007

Delanderseller Kasanfm

Chandrasekhar Korapati<sup>7600</sup> Carroll Ave Takoma Park MD 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** M. /Medical Lorenzo Davis November 4, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4167 Southern Avenue #101 <u>Capitol</u> Heights If Under 24 Hrs Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1**∑**M 2□F Months Davs Min. 578-52-0779 28. 1939 Washington, 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Prince George's Capitol Heights 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4167 Southern Avenue #101 United States
14. Race - American Indian, Funeral 20743 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Yes, Give Year or Dates: 2 □ No 1 ☐ Yes 2 Ho Specify: Specify: Black þ 3 ☐ Widowed 4 1 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>12 vears</u> Master Plumber Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Son Davis ္ရ Rosie Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alma Tibbs - Sister 417 - 3rd St., NE Washington, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Nat'l Cemt. Nov. 9, 2007 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. ture of Funer I Service Line Ohn 4001 Benning Road, NE Washington, DC 20019 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Artery Disease Years disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). Due to (or as a consequence of): IF FÉMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hypertensive Heart Disease 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Diabetes Mellitus 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 2√□ No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TxYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tra attending physician the the a ģ page 2 should be certificate has funeral director, this After t 24 hours after death Funeral Director: filled in by the

**Funeral** 

Director

should be filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

tal Hygiene.

Mental of Health and Menta item 27 Is marked

permit. Pages 1 Department of H Important; If iter any Injury or o

Physician

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**Examiner** 

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other

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Certification: To 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or/investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D28920 November 8, 2007 30. Name and address of person who completed cause of death atem 23a) (Type, Print) Surinder Singh 7319 A Hanover Parkway Greenbelt, MD 20770 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 3 2007 Registrar

			1 - For State Registra/MEND#18perFH11	State of Marylar /21/07,BW,McCo		nt of H		ental Hy	giene 007	37977
	Physici /Medi		1. Decedent's Name (First, Middle, Last, ZEVA Druc	, Ker				2. Date of De Month	/0 200°	7 9-10AM
	Examir Funeral	ner	4a. Facility Name (If not institution, give Square Fairview  5. Social Security Number 6.	N ROL x / 7. Age (In yrs.	. last birthday) If Und	V EV	Spv 100  If Under 24 Hrs.	8. Date of Bir (Month, Da	4c. County of D	Birtholace (State or Foreign
	Director		101-20-5627 1D  Usuel Residence of Decedent  10a. State 10b. County	100 Ci	Yrs. Months	Days		Nov. 2	5, 1928 Is	rael  10d. Inside City Limits
	the Maryla 28a-f shor	Director		gomeny Si	ilver Spr	ip Code			10g. Citizen of What	1 □ Yes 2 No
	death with ms 23a or	Funerai Dir	8912 Fairview	12. Was Decedent Ever in L	2	091	spanic Origin? (Spec	ify Yes or No	United S	tates
900	ral, or Ite	Ď.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Amed Forces?  1  Yes 2  No If Yes, Give Year or Dates:		2DNo	n, Mexican, Puerto F	tican, etc.)	Specify:	white
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, If a Medical Exercitival be nullised at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT Executiv	rork done d use retired	luring most of workin )	g	Secretar	Í
Maryland 2	2 should be filed and Mental Hygie is marked other aumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Mordechai Poll	ack				<del>unknowi</del>	Bella	Viselberg
	Health and 2 sho Health and tem 27 is mutother trauma		19a. Informant's Name/Relationship (Ty Roberta Drucker, I	Daughter	8912 Fair	view	Road, Silv	ver Spr		20910
Baltimore,	9 0 = 5		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ □  '4 □ Donation 5 □ Other (Specify)	Bet	Place of Disposition (N. cometery, crematory or h David Cer	neter.	y 11/11,		Elmont, N	
Bai	permit. Pag Department Important: I any injury o		21. Signature of Eureral pervice Licens  23a. Part Enter the disease, or compli	3	Torch 254 C	insky arrol	s of Facility Hebrew Fu 1 St., NW	uneral , Washi	Home ington, DC	20012
200	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consec	AS CA	NCE (		respiratory ai	rrest,	Approximate Interval Between Onset and Death  Common of the Common of th
8760,	cate be executed obysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consect  Due to (or as a consect.						
P.O. Box 68	The law requires that the death certificat Ite has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ◯ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1	al death 3 □Ectopic				23d. Date of Month	delivery Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the underlying	cause give	on in Part I.			e to the cause of death?  Probably 4 Munknown
		Completed						24a. Whas autop perfo 1 □ Yes	an 24b. Were prior death	
f Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient 3 ☐ □	Othe Othe	26. Place of Death or: 4 □ Nursing Hom		nne) dence 6 □Other(S	pecify)
sion o	ding h. After fune	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		res 2 □No		now injury occurred	
Divi	i Pire		4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	(y)		ļ.	City or Tov		
	To the Hospital within 24 hours a To the Funeral i completely filled	Medicai		sician: To the best of my kno ner: On the basis of examina and manner stated.	ation and/or investigation	n, in my op	inion, death occurre	d at the time,	date and place, and o	due to the cause(s)
•	Veith Con	2	29b. Signature and title of certifier	erchant	- M.D.	DOC	163159		29d. Date signed (Mo	
_			30. Name and address of person who co AKIL MERCHANT	M.D. JOHNS	+ HOPKINS	HOS	PITAL, 6	D N. WOL	FE ST, BACO	TRILEDM 350M
	Sta Registr		31. Date filed (Month, Day, Year) NOV 13 200	32. Pegistrar's Signa	the Locale	9	,			

		= State Registrar		C	ertificate of l	Death		Reg. N	lo.	
		1. Decedent's Name (First, Middle, L.	ast)				2. Date of		ay Yeer	3. Time of Death
nysicia Medic		Esther Sylv	ia Dickter				Nove	nber	7, 2007	9:45 A M
xamin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town, o	Location of	Death	4	lc. County of De	ath
		Rockville Nursi	ng Home			ville				gomery
neral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birtho	Months Davs	If Under 2	Min. (Montl	of Birth h, Day, Yea	9. B	irthplace (State or Foreign Country)
ector			1□M 2□F	89 <sup>Yr</sup>			Dec.	16,	191/ Ma	assáchusetts
	-	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
event, it is medical. Education that on rolling at	5			•						1 TYYes 2 □ No
	Director	Maryland   Montgon	iery	Silver	10f. Zip Code			100.0	Citizen of What (	Country?
		3355 S. Leisure W	Torld Boules	zard	20906			Tog. C	U. S. A	
	Funerai	11. Marital Status	12. Was Decedent E		13. Was Decedent of H	ispanic Origi	in? (Specify Yes o	or No-	14. Race - An	
	5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 24 N		If Yes, specify Cuba	n, Mexican,	Puerto Rican, etc	.)	Black, Wh	
1	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:			Specify:	√hite
	Completed	15. Decedent's E	Education	16a. D	ecedent's Usual Occup	ation	4	16b.	Kind of Busines	s/industry
	D e	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5-		Give kind of work done in the contract of the	during most (	or working			
	E	12 Years	College (1 to to		Homemaker				Own Hor	ne
	0	17. Father's Name (First, Middle, Las	st)			18. Mother	's Name (First, Mi	iddle, Maide	en Sumame)	
	ToB	David Gilman					enny Lev			
		19a. Informant's Name/Relationship	(Type, Print)	19b. N	lailing Address (Street	and Number	or Rural Route N	umber, City	or Town, State	Zip Code) 20906
		Stanley Dickter	- Husband	335.	S. Leisur	e Wor	ld Blvd.	, Sil	ver Spr	ing, Md.
1		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other place	(8)	Date	20c.	Location - City of	or Town, State
		1  Burial 2  Cremation 3 `4  Donation 5  Other (Spec			Mem. Gdns		1/9/2007	01	ney, Ma	ryland
once.		21. Signature of Funeral Service Lice	ensee Otatile	much	DANZANSKY- 1170 ROCKY	ss of Facility -GOLDB	ERG MEMO	RIAL CKVIL	CHAPELS LE, MAR	INC. YLAND 20852
	+	23a. Part1. Enter the disease, or con	mplications that caused	the ceath. Do not						Approximate
m		shock, or heart failure. List online Immediate Cause (Final	46-	nentia						Interval Between Onset and Death
	l	disease or condition resulting in death)	_ a	consequence of)						
H			H	pertensi						
ı	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of)						
	뒽	cause. Enter Underlying Cause Disease or injury that initiated events								
1	Examine	resulting in death) Last	Due to (or as a	consequence of)	:					
	dicai		. d							
1	edic		0.							
	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		_				23d. Date of d	elivery
	cial	in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	·		_	Month	Day Year
	Physician/M	1 ☐ Yes 2 █ ∕¶o 9 ☐ Unknown	9☐ Unknown							
		Part II. Other significant conditions	contributing to death bu	it not resulting in the	ne underlying cause giv	en in Part I.	23e.	Did tobacco	o use contribute	to the cause of death?
	d by							1 🗌 Yes	2 □ No 3 □	Probably 4 Dunknows
	Completed						24a	Was an	24h Were	autopsy findings available
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	-							es 2 194	¶o 1□Y	es 2 No
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	To	1 Yes 2 No	1 Inpatier		atient 3 DOA	4 Mur	sing Home 5		6 ∐Other (S)	oecity)
	ion	1 ☐Natural 5 ☐ Pending	(Month, Day		iry Wor	k? Yes 2 □ N			july oddallod	
	Certification	3 ☐ Suicide 6 ☐ Could not	be 390 Place of Inju	ırv - At home, farπ	, street, factory, office			ion (Street	and Number or	Rural Route Number,
۱	erti	4  Homicide determine	building, etc		, street, radiory, ornog			or Town, Sta		
1		29a. Certifier 1 Certifying F	Physician: To the best of	of my knowledge,	leath occurred at the tir	ne, date and	place, and due to	the cause	(s) and manner	as stated.
	edical	(Check only 2 Medicel Exa	aminer: On the basis of and manner sta		or investigation, in my o	pinion, death	n occurred at the	time, date a	and place, and d	ue to the cause(s)
	Ž	29b. Signature and title of certifier		1 45	29c. Licens			29d. [	Date signed (Mo	nth, Day, Year)
		(indeep )		MO	DO	064	524		11/08/	2007
I	+	30. Name and address of person who	o completed cause of de	eath (Item 23a) (T	rpe, Print)				ı	
	1									
		DR. SANDEE	P SHARMA, 7	43 SUMME	R WALK DRI	VE, RO	CKVILLE,	MD	20878	

		•	1 - For State Registrar	State of Mary		artment of Hertificate of L		nd Men		eme 0 0 7	37979
	<b>5</b> 1 1 1		1. Decedent's Name (First, Middle, I	.ast)					Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		Ruth S.	<u> </u>	DeMott			11	/07/07		12:15
	Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, or	Location of D	Death		4c. County of D	eath
			John B. Parsons			Salisbur		Dia La a		Wicomi	
	Funeral		Social Security Number     6.	. Sex 7. Age (Ir 1 ☐ M 2 ☑ F	n yrs. last birthday) QG Yrs.	If Under 1 Year  Months Days	If Under 24 Hours	Min. 8. C	Date of Birth Month, Day,	Year) 9. I	Birthplace (State or Foreign Country) W York
	Director		095-09-7809 Usual Residence of Decedent		96 Yrs.			00	0/ 10/ 13	TI NE	W TOLK
	and w	1	10a. State 10b. County	10	c. City, Town or L	ocation					10d. Inside City Limits
	Mary f shc	ō	Maryland Wicomic	'O S	alisbury	*					1 1 Yes 2 □ No
	the 128a-	rect	10e. Street and Number	.00	allobary	10f, Zip Code			10	g. Citizen of What	Country?
	3a or		300 Lemon Hill	Lane, Room 4	6	21801			U	SA	
	death ms 2	Completed by Funeral Directo	11. Marital Status	12. Was Decedent Eve		Was Decedent of His If Yes, specify Cubar	spanic Origin	n? (Specify	Yes or No-		merican Indian, /hite, etc.
9	after	Ī	1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:	ruento micar	11, 610.7	Specify:	
8	raf,	d b	3 X Widowed 4 □ Divorced	Year or Dates:		163 223110					White
ب ا	72 h 'netu	etec	15. Decedent's (Specify only highest of		16a. Dece (Give	dent's Usual Occupa kind of work done d DO NDT use retired;	tion uring most o	of working	1	6b. Kind of Busine	ess/Industry
2	vithlo Pan Pan	ם	Elementary/Secondary (0-12)	College (1-4or 5+)					т	nsurance	Agency
Maryland 21215-0036	lied v lygie ther t	ပိ	12 17. Father's Name (First, Middle, La	st)	DOOK	Keeper	18. Mother's	s Name (Fir		laiden Sumame)	rigericy
anc	ntal Hed of	Be		31)			Leah		-,	,	
Ë	hould d Me mark matic	70	George C. Spare  19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a			ute Number.	City or Town, Stat	e, Zip Code)
Ma	d 2 s th an th an treui treui		Suzanne Murphy/Ni		1	stern Way				-	
e)	1 an Heal Hem 2		20a. Method of Disposition		20b. Place of Disp	osition (Name of	- 1	Date		Oc. Location - City	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If tier az is marked other than "netural", or items 23e or 28e-f show any injury or other treumatic event, I're Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spe	☐Removal from State	Wicomico Park	Memorial	" ; !11	/13/0	7 9	alighuru	,Maryland
Ħ	nit. Fartme artme ortar injur B.	1	21. Signature of Funeral Service		2	2. Name and Addres	s of Facility			allobaci	/1.02 / 2011G
B	Depa Impo any ir		bell of he	une FTF	H	olloway Fu Ol Snow H	neral	Home	PA isburv	Marylan	d 21804
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	omplications that caused the	e death. Do not en	ter the mode of dying	, such as ca	ardiac or res	spiratory arre	st,	Approximate Interval Between
	Pnysician	8 17	Immediate Cause (Final	A . I a	11/00	14.	· ndi	4	11.0	dun	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a co	onsequence of):		0.6.0		0,000	CC	1
	Examiner		Cally castic life list conditions	b							
	י ש	Iner	Saluentially list conditions. if any, leading to immediate cause. Enter Underlying	Due to (or as a or	otisequence of).						
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	angaguanga of):						-
8760,	death certificate be executed e attending physician and od for use as the burial-transit		1000 All In County Exect	Due to (or as a co	onsequence or).						
87	physi the t	Physiclan/Medical		d							
9 ×	leath certific attending p	/Me	IF FEMALE:	23c. If yes, outcome of p	pregnancy					23d. Date of	delivery
Вох	atten atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 €	∃Fetal déath 3í	□Ectopic pregnancy □ Other (specify)				Month	Day Year
		ysic	1 □ Yes 2 □ Na 9 □ Unknown	9□ Unknown							
	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	s contributing to death but n	not resulting in the	underlying cause give	en in Part I.		23e. Did tob	acco use contribut	e to the cause of death?
rds	quires n sigr ald be	d by						_ /	1 ☐ Ye	s 2□No 3□	Probably 4 Unknown
Ö	w requires been signal	Completed							24a. Was ar	24b. Were	e autopsy findings available to completion of cause of
Re	9 7 9	mo					-	_	autopsy perform 1 Yes 2	red2 deat	h?/
ta	ilcien: Th certificate rector, pag	<b>a</b>	25. Was case referred to medical				26. Place o		neck only one		.00 22.10
>	Physicien: this certificanal director.	To B	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	nt 3 DOA Othe				nce 6 Other (	Specify)
0	g Phy erthi eral o		27. Manner of Death	28a. Date of Injury (Month, Day Ye	ear) 28b. Time (	of 28c Injury Work				w injury occurred	
Ö	Attending r death. ector: Aftel by the fune	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	, ,,,,,,,		res 2□No	0			
	i or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin-		<ul> <li>At home, farm, st Specify)</li> </ul>	treet, factory, office		28f.	Location (Str City or Town	eet and Number o , State)	r Rural Route Number,
	itai or irs afte rei Dir led in										
	To the Hospital or Attending Physicien: within 24 hours after death: To the Funerel Director: After this certific rompletely filled in by the funeral director.	edical	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of n aminer: On the basis of ex and manner stated	amination and/or in	th occurred at the time envestigation, in my of	e, date and pinion, death	place, and o occurred a	due to the ca t the time, da	use(s) and manne ite and place, and	r as stated. due to the cause(s)
	To the	Me	29b. Signature and title of sertifier			29c. License	number			d. Date signed (M	fonth, Day, Year)
	4		<b>▶</b> k(\ \ \ ) (.			Dog	251	1.70	4	いいりの	
	100		30. Name and address of person wi	no completed cause of deat	h (Item 23a) (Type			V			
			J.C. Cockey, M	D 1346 S. I	Division	St., Sali	sbury	, MD 2	21804		
ı	Sta Registr		31. Date filed (Month Program)	2007 32. Registrar's	Signature	porte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 1500 November 17 Audrey Rose Ewing 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Ceci1 E1kton Union Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JAN 12, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 ☐ M 2 💢 F Mary land 85 221-12-6467 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 ☐ Yes 2 No Cecil E1kton Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21921 32 Maloney Road 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🗓 No Specify: White 3 ☐ Widowed 4 🎇 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker In Her Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sydney A. McCauley Adelbert E. Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19 Shawn Drive, Elkton, Maryland 21921 Aubrey H. Ewing/Son 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Cherry Hill
Methodist Cemetery
22. Name and Address of Facility,
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkto 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cherry Hill, Maryland 21. Sign sure of Funeral Service Licensee Elkton, Maryland 21921

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important; If Item 27 is marked other than "n
any Injury or other traumatic event, the Medii
once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rai", or items 23a or 28a-f show Examiner must be notifled at

Directo

Funeral

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Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

reral Director; After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit within 24 hours a

To the Funeral Completely filled

Division or Vital Records, P.O. Box 68760, ぐ

shock, or heart failure. List on	mplications that caused the death. Do not enter the moy one cause on each line.  A Cute My card			Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. A Cute VI 3227 &  Due to (or as a consequence of):	11/010	- [13 d	3 days
Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	specify)	Mod	
Part II. Other significant conditions	contributing to death but not resulting in the underlying	cause given in Part I.		ribute to the cause of death?  3 ☐ Probably 4 ☐ Unknow
			performed2	Were autopsy findings availab prior to completion of cause of death? I ∐Yes 2 ☐ No
25. Was case referred to medical		26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ [	OCA Other: 4 Nursing Hor	ne 5 ☐ Residence 6 ☐ Oth	er (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how injury occurr	
3 Suicide 6 Could not 4 Homicide determine		ory, office 2	28f. Location (Street and Numb City or Town, State)	er or Rural Route Number,
29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of my knowledge, death occurre aminer: On the basis of examination and/or investigati and manner stated.	ed at the time, date and place, a on, in my opinion, death occurr	and due to the cause(s) and ma ed at the time, date and place,	anner as stated. and due to the cause(s)
29b. Signature and title of certifier	& mo	9c. License number D C 5902	29d. Date signe	d (Month, Day, Year) 2 0 0 7
30. Name and address of person wh	o completed cause of death (Item 23a) (Type, Print)	redral St	Elkton 1	MD 2192

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,-Year)

NOV 2 8 2007

32 Registrar's Signature

CHICINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19.2007 YUT GUNG ENG /Medical 4c. County of Death 4b City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PLa harle ivista nter Birthplace (State or Foreign Country) If Under 1 Year If Under 24 8. Date of Birth (Month, Day, **Funeral** Days Year) Months Hours 1 ★M 2 F 068-54-3200 76 JULY 10,1931 CANTON, CHINA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Director CHARLES WALDORF MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number J. S. A. 14. Race - American Indian, 13045 ZEKIAH DRIVE 20601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced CHINESE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event the Man Elementary/Secondary (0-12) College (1-4or 5+) 12 CHEF RESTAURANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHU YEE LING SUEY OI HUEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ZEKIAH DRIVE WALDORF, MD 20601 KWOK ENG / SON 13045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State NOV. 25, 4 ☐ Donation 5 ☐ Other (Specify) CEM LORRAINE PRK. 2007 BALTIMORE. 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 21. Signature of Juneral Service Licenses 5635 WASHINGTON AVE LA 20646 PLATA. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PATERV ORGINARY wa **Physician** /Medical Due to (or as a consequence of Examiner ON GES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of and burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ş 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performe death? 2 KNo 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2**X** No 1 Inpatient Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t il or Attending Patter death. Director: After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation in my opinion death area. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24 hours a Hospital within 24

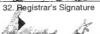
31. Date filed (Month, Day, Year) State NOV 2 Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Ht

hen

2007



and manner stated.

n 23a) (Type, Pr

29c. License number

29d. Date signed (Month, Pay, Year)

Secita 10.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) / Month Physician JAMES ALEXANDER EPPS, JR. Vovember /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours **XX** M 2□ F 1937 SOUTH CAROLINA APR. 04, Director 249 56 6107 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at XX Yes 2 No Director PRINCE GEORGES BOWIE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number perr it. Pages 1 and 2 should be filed within 72 hours after death with Dep intent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be note. UNITED STATES 1442 KINGS MANOR DRIVE 20721 Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★K Yes 2 □ No If Yes, Give Year or Dates: 1958-82 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married XX Married 1 ☐ Yes XX No Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NAVY DEPARTMENT TELECOMMUNICATIONS SPECIALIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES ALEXANDER EPPS MARY FLOYD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BOWIE,MD 20721 1442 KINGS MANOR DRIVE CAROLYN EPPS / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXCremation 3 ☐ Removal from State METROPOLITAN CREMATORY 11/19/07 ALEXANDRIA, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Properal Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND 4308 SUITLAND ROAD SUITLAND, MD 2 SUITLAND, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final META STATIC AWCEN **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** EPSI Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine RENAL law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Ulaknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 1 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 Tes 2 N 1 Inpatient မ 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Injury or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760, Jospitar - 4 hours after dec. - - real Director: After the fu 24 hours a Hospital

Maryland 2121

State Registrar

DHMH 17 Rev 1/2001

filed (Month, Day, Year) 3 2007 NOV 1

cil

29b. Signature and title of certifier

, MD. 7500 Hanover Parkway Suite 101A, Greenbelt, MD. 20170 D. George 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

D58182 November 12, 2007

			For State Registrar	State of	Marylan		artment o rtificate d				giene Reg. No.20	07	37983
	Physicia /Medic		1. Decedent's Name (First, Middle, L Helen Eising		line					2. Date of Dea Month	ber 12	Year 2007	3. Time of Death 3:45 PM
	Examin	land.	4a. Facility Name (If not institution, gi Washington Cou				Ная	n, or Location of gerstow	n		4c. County of Death Wshington County		
ă.	Funeral Director			Sex 1□M 2【XTF	7. Age (In yrs. I	Yrs.	If Under 1 Ye		Min.	8. Date of Birt (Month, Day Sept	1 1925	9. Birthp Court Penn	lace (State or Foreigr try) sylvania
	Maryland -f show led at	tor	10a. State 10b. County Maryland Washi	ngton	10c. City	y, Town or Lo	cation serstown	1				1	0d. Inside City Limits 1X Yes 2 No
	with the 3a or 28a st be notif	Funeral Director	10e. Street and Number 1044 Benjamin	Place		· · ·	10f. Zip Coo	21740			10g. Citizen of	What Cour	ntry?
200	s 1 and 2 should be filed within 72 hours after death with the Maryland fenetand Mental Hygiene. The that manked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	by Funera	11. Marital Status  1 Never Married 2 Married 3 Nidowed 4 Divorced	12. Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da	9		Was Decedent If Yes, specify ( 1 ☐ Yes 2【☐			cify Yes or No Rican, etc.)	14. Rac Bla Specif	ce - Americ ck, White, fy: W	
2-2-1	within 72 hou iene. than "natura he Medical E	Completed	15. Decedent's to (Specify only highest go	Education rade completed)  College (1-2)	-4or 5+)	16a. Dece (Give life.	dent's Usual Oo kind of work do DO NOT use re Homema	one during mos tired)	st of workin	ng .	16b. Kind of B		esidence
ומוות ע	uld be filed Aental Hygi rked other tic event,	To Be C	17. Father's Name (First, Middle, Lass Charles Eising					A1:	ma Le	verent	Maiden Surnai Z Eisin	ger	
, Maly	and 2 shoresalth and North		19a. Informant's Name/Relationship Robert R. Ente			1044	Benjam	nin Pla	се На	gersto		land	21740
	permit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any Injury or other trau		20a. Method of Disposition  1X Bunal 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec	ify)	State Re	st Hav		etery    l	Nov 1			town	Maryland
	Physician /Medical Examiner		23a. Part1. Enter the disease or conshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death)	mplications that cally one cause on ea	aused the death ach line.	h. Do not en	331 Eas	dying, such as	1vd.	N. Hago r respiratory a	erstown		ral Home  land 21742  Approximate Interval Between Onset and Death
,00,00	icate be executed physician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequence or as a consequence								
O. DOY 0	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		irth 2 ☐ Feta ant at time of d	Ideath 3	Ectopic pregn Other (specif					ate of delive	ery Day Year
. L (SD)	quires that I n signed by uld be deta	by	Part II. Other significant conditions	contributing to de		ulting in the u	nderlying cause	e given in Part i	1.				he cause of de <i>a</i> th? pably 4
	The law re ate has bee	Completed	Degenerative	Joint	Pulmo	_	Dise	20		24a. Was autor perfo		Were auto prior to co de ath? 1 \( \sum Yes	opsy findings available impletion of cause of
יומ	clan: sertifics ector, p	Be C	25. Was case referred to medical examiner?	Hospital:				26. Place Other:	e of Death	(Check only o			
5	nding Phys th. : After this e funeral dir	tion: To	1 ☐ Yes 2 ☐ Mo  27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of (Mont	npatient 2  of Injury h, Day Year)	28b. Time of Injury	f 28c.	1njury at Work? 1 ☐ Yes 2 ☐	2		dence 6 □Ot how injury occu		fy)
	tal or Atten	Certification:	3 Suicide 6 Could not determine	Zoe. Flace	of injury - At hong, etc. (Specif	ome, farm, st	reet, factory, of	fice	2	28f. Location ( City or To	Street and Num wn, State)	ber or Run	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical		Physician: To the aminer: On the ba and manr	asis of examina								
	To th withir To th comp	Me	29b. Signature and title of certifier	Desca	2		29c. Lid	cense number	4		29d. Date sign	ed (Month,	Day, Year) 2, 2017
5 H	-7		30. Name and address of person wh	o completed caus	e of death (Iten	n 23a) (Type,	Print) 251	E. a	uir t	MD	2174	0	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 37984 State Registrar Amend 10b, perFh, g874, 12/7/07 TT Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:30A November 12, 2007 Vina L. Edwards /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **HeartFields** Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 25, 1916 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2√2 F 91 Michigan Director 396-03-7288 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Carrol1 : If item 27 is marked other than "natural", or items 23a or 28a-f shor or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Frederick Mt. Airy Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5281 Buffalo Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White <u>ک</u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Kuchan Anna Joe ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mt. Airy, MD 21771 5281 Buffalo Road, Kingsley Edwards/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 11/16/2007 Brentwood, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service License 8 E. Ridgeville Blvd., Mt. Airy, MD 21771 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HLZHEIMERIS DRMENTI **Physician** 10 YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) ed by the detached 9□Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 212 No 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Tes 2 No 卢 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 035965 NOULMBER Harala 30. Name and address of person who completed cause of peth (Item 23a) (Type, Print) B. HARDING, MO. 18111 PRINCE PHILLIP DR. #300 OLNEY () AU (0) 32. Registra s Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 37985 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOV th 08<sup>ay</sup> 2007<sup>ar</sup> 0301 **Physician** David Michael Edwards, Sr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1/**X**M 2∏ F 54 Oct 25 1953 218-62-7643 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M dical Examiner must be notified at 1 ☐ Yes 2 No Westminster Director MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21157 839 Snowfall Way by Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2½ If Yes, Give Year or Dates: 2**7** No 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Arby's Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shirley Mayers Norman Edwards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 839 Snowfall Way Westminster, MD JoAnne Edwards/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 11/12/2007 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hampstead, MD Carroll Cremations, Inc 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Pritts funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part Tenter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PANCREATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Year signed by the atte Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 2 No 1 TYes To the Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ၀ 1 Inpatient 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29d. Date şigned, (Month, Day, Year) 29b. Signature and title of certifie 10059551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POOLE RD WESTMINSTER MD 21157 700A ( OURISIANKAR 31. Date filed (Month, Day, Year) State NOV 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 02007 Marguerite M. Forte lovember 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospita et Easton Easton Talbor emorial 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🖾 F 215-34-3111 94 Aug 15, 1913 Boston, Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1X Yes 2 No Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Dutchman Lane 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3₺Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Proof Reader Merkle Press 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John M. Moore Marguerite Lillian Buckler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard D. Gibbons - Son 2718 Luthy Road, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 11/11/07 Alexandria, Virginia 4 Domation 5 Dother (Specify) 21. Sign ture of Funeral Service Licent 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 MO1491 27a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 26 DSIS cuy 5 disease or condition resulting in death) Due to (or as a consequence of): In testinal ischemia Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events testina resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24a, Was an

**Physician** /Medical Examiner

Important: If It any Injury or c

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

is 1 and 2 should be filed within 72 hours after death with 71 Health and Mental Hygiene. It was 23a or Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a cother traumatic event, the Medical Examiner must be a

Baltimore, Maryland 21215-0036

Box 68760,

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Division or Vital Records,

Pages 0 Directo

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Completed

Be

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as the burial-transi

attending physician for use as the buria signed by the a peen page 2 s certificate After

Examiner reral Director; /

death certificate be executed Physician/Medical ģ Completed P Certification: within 24 hours a Medical

1□ Yes 21 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

5 ☐ Pending investigation

6 ☐ Could not be

Hospital:

N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

and manner stated.

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 9, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219 South Washington St., Easton, MD 21601 Lakshmi Vaidyanathan, MD

State Registrar

31. Date filed (Month, Day, Year, NOV 1 3 2007



State of Maryland / Department of Health and Mental Hygiene 37987 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Nikita Ν. Floyd-Hawkins \_P M November 2007 11:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3675 Solomons Island Rd. Harwood Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 😽 F 578-98-0818 Director 29 1978 Nov. Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits iral", or Items 23a or 28a-f shov Examiner must be notified at Director 1 ☐Yes 2 ☐ No MD Prince George's Capital Heights 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? within 72 hours after death with 290 Possum Court 20743 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Battimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Black 3 Widowed 4 Divorced er than "natural", the Medical Exa Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th Student None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Terry Hawkins Wanda Floyd ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Glenn/Mother 290 Possum Court Capital Heights, Maryland 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State permit. Par Department Important: if any injury or 4 Donation 5 ☐ Other (Specif) Riverdale Crematory 11/10/2007 Riverdale, Maryland 22. Name and Address of Facility J. B. Jenkins Funeral Home f Funeral Service Lio Signature 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) RECTAL CANCER WIDELY METASTATIC /Medical Due to (or as a consequence of): Examiner HIV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the death certificate be executed as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1☐Live birth 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | signed by the a d be detached f 1 Yes 2 No 9 Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed need 24a. Was an has le 2 autopsy performed? Yes 2 2 No page certificate 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Nother (Specific Mandrin Hospice House Hospital: 1 ☐ Yes 2 🛣 No ۵ this 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 XNatural 5 ☐ Pending investigation n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier D 21438 November 6 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 445 Defense Highway Annapolis, Maryland 21401 Michael J Lapenta 31. Date filed (Month, Day, Year) NOV 1 3 2007 32. Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 4:00 pm Glenn Eugene Funkhouser November 6 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8270 Reservoir Road Fulton Howard 5. Social Security Number If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1⊠M 2□F 217-28-7250 76 October 7, 1931 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Howard Fulton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8270 Reservoir Road 20759 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1⊠Yes 2□No If Yes, Give Year or Dates:Korean War 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant United States Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Funkhouser Effie Kline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah R. Funkhouser - Spouse 8270 Reservoir Road, Fulton, Maryland 20759 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lincoln Crematory 11/9/2007 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Va ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest re. List only one cause on each line. 23a. Part1. Enter the dis as shock, or heart fall e. Approximate Interval Between Onset and Death Immediate Ca Final disease or Indition resulting in death) SEARS Due to (or as a consequence of) Sequentially list conditions, than, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24a. Was an

**Physician** /Medical Examiner

Examiner

Physician/Medical

by

Completed

Be

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Certification:

Medical

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Be Completed by

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed physician and s the burial-transit SB signed by the attending d page 2 s director this funeral within 24 hours after death. To the Funeral Director:

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician:

IF FEMALE: 23b. Was decedent pregnant

25. Was case referred to medical examiner?

5 Pending

investigation

determined

6 ☐ Could not be

1 ☐ Yes 2 Dolo

27. Manner of Death

2 Accident

4 THomicide

(Check only one)

3 ☐ Suicide

29a. Certifier

1 Ratural

autopsy performed? 1☐ Yes 2 2No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2□No

26. Place of Death (Check only one)

Other: 4 Nursing Home Mesidence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year) NOVEMBER 7, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DIBERMAN, MO 6565 N. CHARLES ST. SWITE 209 BALTIMORE, MD 21204

State Registrar 31. Date filed (Month, Day, Year) **NOV 13 2007** 

1 Inpatient

28a. Date of Injury (Month, Day Year)



2 ER/Outpatient 3 DOA

M

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			For State	State	of Marylan		artment o rtificate d						07000
			Registrar			Cei	illicate (	Deau		2. Date of De	Reg. No.	<u> </u>	3. Time of Death
	hysicia	an	1. Decedent's Name (First, Middl							Month	Day	Year	
	/Medic	_	Paul David	Fosko						Noveml		, 2007	10:04 P M
	Examin	24	4a. Facility Name (If not institutio	n, give street and r	number)		4b. City, Tow	n, or Location	of Death		4c. (	County of Death	n
			Montgomery G	eneral Ho	ospital			Olne			Mo	ntgomer	·y
Fu	ineral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y Months Da	ear If Unde ays Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da	th av. Year)	9. Birth	nplace (State or Foreign untry)
	rector		179-28-9492	1 M 2 □ F		72 Yrs.	Worthing	110010					sylvania
70	25 30-1		Usual Residence of Decedent										
ylan	at		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
Mar	fied	tor	Maryland	Montgomer	rv	Rock	ville						1 ☐ Yes 2 █ No
the	noti	Director	10e. Street and Number				10f. Zip Co	de			10g. Citiz	en of What Co	untry?
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leath	mus 2	Funeral	11. Marital Status	12. Was D	ecedent Ever in U	l.S. 13.	Was Decedent	of Hispanic O	rigin? (Spe	ecify Yes or No	o- 1	14. Race - Amei	
ter d	iter Iner	튑	1 ☐ Never Married 2 ☐ Mar	ned 1 1 Ye	Forces? s 2 ☐ No		If Yes, specify			Hican, etc.)		Black, White	
Is a	ram xam	by	3 ☐ Widowed 4 ☐ Divorced		Give r Dates: <b>19</b> 56 <b>-</b>	-80	1 ☐ Yes 2 🙀	No Specify	V:			Specify: Wh	ite
<u> </u>	attura al E		15. Deceder	nt's Education		16a. Dece	dent's Usual O				16b. Kir	nd of Business/	Industry
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d be	ed o	Be	Paul Fosko					9	Susan	Petoni	iak		
Ital ylail of Ital 3-0000 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene.	mark	ဥ	19a, Informant's Name/Relation	ship (Type, Print)		19b. Maili	ng Address (St					Town, State, 2	Zip Code)
d2s than	7 is trau		Mary Louise Fo		5								MD 20853
Tand 2	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u>		20a. Method of Disposition		20b.	Place of Dispo	sition (Name o	of !		Date		cation - City or	
Pages Pent of I	or o		1√Burial 2 ☐ Cremation		om State	cemetery, cre	matory or othe	rplace)	Jan.	9,			
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pant permit. Departn	impor any in once.		21. Signature of Funeral Service	Licensee	$\circ$		ancisd A						
<u> </u>	느~이		Lund	5 6	305							Spring	Approximate
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iiicat	g phy as th	edi								<del></del>			
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leath o	atte I for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pr	ve birth 2□Fet regnant at time of		⊒Ectopic preg ⊒ Other <i>(speci</i>					Month	Day Year
i ĝ	y the	Physician/Me	9 Unknown	9□Ur	nknown								
that	ed b deta		Part II. Other significant condit	ions contributing t	o death but not re	sulting in the u	ınderlying caus	se given in Par	t I.	23e. Did	tobacco u	ise contribute to	o the cause of death?
ecords,	sign d be	Completed by	Pro	date (	3A					1 🗆	] Yes 2[	□ No 3□P	robably 4 Onknown
	peen	ete								24a. Wa	s an	24b. Were a	utopsy findings available
	has le 2	d d								aut	opsy formed?	prior to death?	completion of cause of
<u>.</u> f	cate,	S								1□ Yes	2 No	1 ☐ Yes	s 2□No
VIICALI	ertifi	Be	25. Was case referred to medic examiner?					Othor		h (Check only			
hysi	this o	2	1 Yes 2 No due	.,		-ET/Outpatie		4	Nursing Ho			6 □Other (Spe	ecify)
ng P	offer the	ü	27. Manner of Death 1 ☐ Natural 5 ☐ Pend	/8	ate of Injury Month, Day Year)	28b. Time (		. Injury at Work?		28d. Describe	e now injur	y occurred	
sion endi	or: A	Sati	2 Accident inves	tigation			М	1 ☐ Yes 2	∐ No				) - ( D - ( ) ( ) - ( )
I or Attending Phy after death.	irect by 1	Certification:		:	lace of injury - At h uilding, etc. <i>(Sp</i> ec	nome, farm, st sify)	reet, factory, o	office		28f. Location City or T	(Street an own, State	id Number or H e)	lural Route Number,
Ital o	led ir	Cer											
losb hou	<b>To the Funeral Director:</b> After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1- Certify (Check only 2 Medical	ring Physician: To al Examiner: On th	the best of my kn ne basis of examin	nowledge, dea nation and/or i	th occurred at nvestigation, ir	the time, date my opinion, o	and place death occu	, and due to th rred at the tim	e cause(s) e, date and	) and manner a d place, and du	s stated. le to the cause(s)
the Frin 24	the F	edical	one)	and r	nanner stated.		1						
To I	<b>10</b>	Σ	29b. Signature and title of certif	er	Mia	1. Direc	29c. L	icense numbe	er er		29d. Da	te signed (Mon	un, vay, rear)
227	- 1		Montrel	the un.	d Dens	EM		0050	110			1/8/0	/
JA.	17-		30. Name and address of perso	n who completed	cause of death (Ite	em 23a) (Type	, Print)		1.4	2	/	77	
			Mich	and Ke	or MI)	IP.	101 Pm	mee 11	421.6	11,0	may,	20832	
	Sta	ate	31. Date filed (Month, Day, Yea	3 2007	2 egistrar's Sigr	nature	Deal D						

State of Maryland / Department of Health and Mental Hygien ? 1

For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician PERGUSON NOVEMBER 12, 2007 ILA AMLLEY /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHESTERTOWN If Under 24 Hrs. CENTER RIVER HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Yrs. 003 30 8088 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location r than "natural", or itams 23a or 28a-f show the Medical Example must be notified at 1 Yes 2 □ No CHESTERTOWN KENT Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET 21620 U.S.A NON Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than any injury or other traumatic event, the Magneta Elementary/Secondary (0-12) College (1-4or 5+) MAKER tomemaces 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MILDRED FLETCHER 2 JAMES ARNALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHESTERTE IN MADE DAVIGHFERGUSON 21620 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/14/07 CHESTER, CHES APEACY CRE-TATIONS
22. Name and Address of Facility \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 205 GREEN HEROM WAY 21620 VI WILLIAMS, JR CHESTERTOWN, IMD 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Failure
Due to (or as a consequence of): /Medical Examiner BAMeluguis Carcinuma to BRAIN, LIVER, Splee. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last letASTATTC Due to (or as a consequence of): Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician al s the burial-t Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 🗍 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, FTBREAT Cancinum 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No And Diverbaliti 24a. Was an Diverticulosis autopsy performed? certificate 1 ☐ Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? Certification: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D23889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. ARRABAL Street, CHESLENDOWN, Med. TR-HID 223/1/86 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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### Shock, or heart failure. List only one cause on each line.    Physician (Medical Examiner)   Medical Cause (Final death)					nsee /	uneral Service Lice	21. Signiture V Fur	2	Depermit Depermit Import any in	Ball
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30. Name and address of person who completed cause of death (item 23a) (Type, Print)	11.3116	29c. Licer	0	yme	Peill	title of certifier	29b. Signature and	Σ :	withi To the	,
	Huse the D-1, therekick Mg	HULST	1011	801	completed cau	ress of person who	30. Name and address		6	1
State Registrar  31. Date filed (Month, Day, Year)  NOV 1 5 20 07  State Registrar	Specie	Sperte	ature #	Registrar's Signa			31. Date filed (Mont	υç		

Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 20 hours often death

			Please					Ensure Al	-	_	ible.		
	-	For State		State of	Marylan		artment of H r <i>tificate of L</i>	ealth and M				07000	
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Physicia	an	Setsuko Shinoda Favre							Month	11 10 2007 7:00 A			
/Medic Examin		4a. Facility Name (/			ber)		4b. City, Town, or	Location of Death		4c. County of Death			
		41 High	Sheriff	Trail			Ocean C			Worcester			
Funeral		5. Social Security N		Sex 7	'. Age (In yrs.	last birthday) Yrs.	Months   Days   Hours   Min   (Month, Ua)				y, Year) Country)		
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fter d	Fun		ried 2 🛣 Married	Armed Ford	ces? 2 <b>X</b> TNo		If Yes, specify Cuba 1 ☐ Yes 2 ☐ <b>X</b> No		Rican, etc.)	1	ack, White,		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pepratrent of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's N						and Number or Run					
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r Atte er de: irecto	Certification	3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	ad Zoe. Place	of injury - At h	ome, farm, st	reet, factory, office		28f. Location (Sti City or Town	reet and Nur , State)	nber or Ru	ral Route Number,	
urs aft		9.	Ja	Discovering Testing	bank of man law		Although and the time to	imp. data and place	and due to the e	augo(o) and i		etated	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)	2 ☐ Medical E	xaminer: On the ba and manr	asis of examina	ation and/or in	nvestigation, in my	ime, date and place, opinion, death occu	rred at the time, d	ate and plac	e, and due	to the cause(s)	
o the rough	Med	29b. Signature an	d title of certifier	and mon			29c. Licens	se number	2	9d. Date sigr	ned (Monti	n, Day, Year)	
F>F0		DUT	(min)	-			DI	672)		11	131	07	
0.0		30. Name and add	dress of person w	ho completed caus	e of death (Ite	m 23a) (Type	, Print)	0,51	. 0				
BA 10		TAN, CO	RESTAN	E 134	egistrar's Sign	NV151	M 51,5	ausny	MD				
Sta Registi		31. Date filèd (Mo	onan, Day, Year)		gional a olyn	L .	1	O					
OHMH 17 Rev 1/2	- "		NOV 1 3	2007	die .	D 19	Sant						

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Redistrar	Certificate of L	Death	Reg	g. No. 200	7 3799:
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)	orgo		Date of Death     Month     November	Day Year	3. Time of Death 2249 hrs
ieulcai Exami	IICI	Donald Michael Ge  4a. Facility Name (if not institution, give street and number)		. City, Town, or Location of		4c. County of Death	
		Union Hospital		Elkton		Cecil	
Funeral Director			yrs. last birthday)	If Under 1 Year If Under Months Days Hours	er 24Hrs. 8. Date of Birth	n(MM/DD/YYYY) g. Birt Foreig	hplace (State or Maryland
Director		212-76-5971   1X M 2 F 34	Yrs.		June 4	, 19/3	untry)
any		Usual Residence of Decedent           10a. State         10b. County         10c.	. City, Town or Location	1			10d. Inside City Limits
Maryland 28a-f show any d at once.	ō	Maryland Cecil	E1kton				1 X Yes 2 No
Maryl r 28a-f	Director	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	
r death with the Maryland or items 23a or 28a-f sho must be notified at once.		132 1/2 Cathedral Street  11. Marital Status	rin IIS 113 Was	21921 Decedent of Hispanic Orig	rin2 / Specify Ves or No.	United Sta	tes can Indian, Black,
eath w items	Funeral	1 X Never Married 2 Married Armed Forces?	If Yes	, specify Cuban, Mexican		White, etc.	San Indian, Siasin
ا احاث على	by Ft	3 Widowed 4 Divorced If Yes Give Year or Dates:	1 Y	es 2 X No specify:		Specify: Whi	
hours natur Exami		15. Decedent's Education (Specify only highest grade complete		Usual Occupation (Give t of working life. DO NOT		16b. Kind of Business/I	ndustry
136 hin 72 e. than than	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Welde	r		Construc	tion
5-0C led wit Hygien other the M		17. Father's Name (First, Middle, Last)		18.Mother	's Name (First, Middle, M	laiden Surname)	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once	o Be	Nelson Allen George, Sr.  19a. Informant's Name/Relationship (Type, Print)	10h Mailing /	C1 Address (Street and Nun	oia Gay Hic		Zin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours al Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	ř	Nelson A. George, Sr./Fathe	1	falo Meadow			
e, C		20a. Method of Disposition		on (Name of cemetery,	Date November	20c. Location - City or West Ches	Town, State
Pages rent of unt: 11		Burial 2 Termation 3 Removal from State Donation 5 Other Specify:	R.A. Ferris 8	Co., Inc.	24, 2007	Pennsylva	nia
Baltimore, permit. Pages I ar Department of Hee Important: If itel		21. Signature of Funeral Service Licensee	22. Na Hic	me and Address of Facilit ks Home for	Funerals. F	P.A.	
Physician	-	21. Signature of Funeral Service Licensee  23a. Part I. Enter the disease, or complications that caused the complete the complete that caused the complete the complete that caused the complete that caused the complete the complete that caused the	death. Do not enter the	W. Stockton	St. Elkto	on MD 2192	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Head Injunes					Between Onset and Death
:aminer	=	or condition resulting in death)  Due to (or as a consequent	nce of):				
	-	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence)	nce of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	nno of):				
id uted		events resulting in death) Last Due to (or as a consequer d.	rice ory.				
760, crate be executed physician and the burial - transit	Medical	UNPENDED AMENDED					
Box 68760, s death certificate be the attending physic of for use as the bur		IF FEMALE: 23b. Was decedent pregnant in the		I death 3 Ectopi	c pregnancy	23d. Date of deliver	y Day Year
Box 68 e death certifi the attending	iciar	past 12 months?  4 Pregnant at time	of doath	I death 3 Ectopi er (Specify)	c pregnancy	, woner	
Bo he deat y the at hed for	Physician	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but	not reculting in the un	derlying cause given in P	ert 1 23e Did to	bacco use contribute to	the cause of death?
s, P.O. nires that the signed by d be detach	þ	Part II. Other Significant conditions Contributing to death but	Thou resulting in the bir	deliying cause given in i		2 ✓ No 3 Proi	
ords, w require us been si should b	Completed				24a. Was a		topsy findings available completion of cause of
ecol ne faw te has ige 2 sh	dmo				perfor	med? death?	
ital Reco Ician: The law certificate has	Φ	25. Was case referred to medical		26.Place of Death			
of Vital Records, ng Physician: The law require ther this certificate has been si neral director, page 2 should t	To B	TV Yes 2 No	2 FR/Outpatient			Residence 6 Othe	r:
n of \ iding Ph; h. After tl e funeral	ion:	27. Manner of Death  1 Natural 5 Pending FOUND:	28b. Time of Inj FOUND:	ury 28c. Injury at Worl	Driver auto f	ixed object collision	on
Division tal or Attendi rs after death. al Director: A	ertification:	2 Accident Investigation Nov 17, 2007 28e. Place of Injury	2210 hrs - At home, farm, street,	factory, office building, e			ıral Route Number, City
Division pital or Attene ours after death freal Director:	Certi	Suicide Socialists	Road / Highway		623 East Pula	tate) ski Hwy and Old Ned	k Road, , MD
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier (Check only one)  Certifying Physician: To the best of my known one)  Certifying Physician: To the best of my known one of the basis of examination of the basis of the basis of examination of the basis of the basis of the basis of the basis of the basis of the basis of examination of the basis of th	owledge, death occurre	ed at the time, date and pl	ace, and due to the caus	e(s) and manner as stat	ed. le cause(s)
To the To the comp	Medical	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	
<i>l.</i>		/ // // _		O.C.M.E.		November 18, 2	•
4		30. Name and addr is of perion who colonies cause of death					
OCME	1 (1)	Mary G. Ripple-MD. Deputy Chief Medical I	Examiner 111	Penn Street, Baltim	nore, MD 21201		
St Regis	ate trar	31. Date filed (Month Pay Year) 8 2007 32. Registrar's Si	ignature	Select 1			

State of Maryland / Department of Health and Mental Hygiene 37994 For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2135 November 19, 2007 Leona Mae Godfrev /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Havre de Grace
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Harford Memorial Hospital Harford 8. Date of Birth (Month, Day, ) 9/7/1921 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕱 F Yrs. 86 West Virginia Director 216-28-2085 Usual Residence of Decedent 10d Inside City Limits 10c. City. Town or Location 10a State 10b. County or 28a-f show 1 XYes 2 No MD Harford Aberdeen Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 415 Lorraine Street 21001 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home permit. Peges 1 and 2 should be filed v Depertment of Heelth and Mental Hygier Important: If Item 27 ie marked other It eny Injury or other traumetic event, Its once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Perry Rexroad Lula Walke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Norton (Daughter) 415 Lorraine St. Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/26/07 4 Donation 5 Cother (Specify) Entombment Harford Mem. Gdns Aberdeen, Maryland 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician bha /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the ynderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ZNO 3 Probably 4 Unknown 24b. Were autopsy findings available rior to completion of cause of death?

1 □ Yes 2 □ N 24a. Was an autopsy perform certificete 1 ☐ Yes 20 No or Attending Physician: To Be 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 2 LEN Outpatient 3 DOA After thi funeral of 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 4 Thomicide within 24 hours after To the Funeral Dire To the Hospital 1 Conflying Physician: To the best of my knowledge death occurred at the time, that and place, and the time, date and place, and the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D19589 8 Law Street th (Item 23a) (Type, Print) 3 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2007 NOV 28

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٠			for State Registrar		Oll	ALC OF IVI	ai yiai i	-	rtificat				ieritai i i	Reg. No	Z U	07	37	7995
ĺ	Physici /Medic		1. Decedent's Name	_		Lorraine	e Gue	errant					2. Date of D Month Novem	Da	y 08 2	Year LCO 7		of Death
	Examir	er	4a. Facility Name (III		_					Town, or	Location	of Death		4c.	. County o	BOT		
	Funeral Director		5. Social Security N 578-03-3490	)	6. Sex 1 ☐ M 2		e (In yrs.	last birthday) Yrs.	if Under Months	T 1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D Sept. 4	rth ay, Year) , 191.	3 N	9. Birthpla Counti lashing	ice (State y) gton, I	e or Foreign
	land ow at		Usual Residence of 10a. State	Decedent 10b. County			10c. City	y, Town or Lo	cation							10	d. inside	City Limits
	a-f sh	ctor	Maryland	Prince	George		Oxo	n Hill									1 □ Y€	es 21 No
	vith th	Funeral Director	10e. Street and Nur						10f. Zip	207	V.5				tizen of W	hat Count	y?	
	eath v	eral	_5615 Wood1a	and Drive		as Decedent	Ever in U	S 13	Was Dece			ngin? (Sp	ocify Yes or N		SA 14. Bace	- America	n Indian.	
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Marri 3 🛣 Widowed		l If	as Decedent med Forces? ☐Yes 2 🔼 I Yes, Give ear or Dates:	No .		if Yes, spe	T.	Specify		ecify Yes or N Rican, etc.)		Black	, White, e White	tc.	
<u>.</u>	"natu	leted	(Spec	15. Decedent	's Education of grade com	pleted)		16a. Dece	dent's Usu kind of wo DO NOT u	al Occupa	ation during mo	st of work	ng	16b. K	ind of Bus	iness/Ind	ıstry	
717	d withir giene. er than the Mo	Be Completed	Elementary/Seco 10th		Co	ollege (1-4or 5	5+)	-	emplo					Bea	auticia	an		
yland	ould be file Mental Hy arked othe atic event,	To Be (	17. Father's Name ( <i>First, Middle, Last</i> )  Charles J. Barrett  Mabel Weigert									e, Maiden	,					
Mar	nd 2 sho lth and 27 Is m rtraum		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Kenneth A. Guerrant/Son  5615 Woodland Dr. Oxon Hill, Md. 20745								or Town, S	State, Zip (	Code)					
Baltimore,	es 1 ar of Hea f Item 3		20a. Method of Disp		3 D Romov	al from State		Place of Dispo emetery, crea					Date		ocation - C	-	vn, State	
	Pag tment tant: I		4 □ Donation	5 Other (S	pecify)	al IIOIII State	Mary	land Ve			- 1				tenhan			
pal	permit Depar Impor any in		Lege	ineral Service	Pales	p'			6160 C	xon H	i11 R	oad Ox	rge P. K on Hill,	Mary		2074.	5	
H		X.	23a. Part1. Enter the shock, or hea immediate Cause (		complication only one ca							s cardiac	or respiratory	arrest,			Approxim Interval E Onset an	Between and Death
-	Physician /Medical		disease or condition resulting in death)	n	a	Resp Due to (or as		uence of):	fail								Da	45
	Examiner	_	Sequentially list co	nditions,	b		jesti		teart	- fc	ilu	e					Do	rys
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einter Underfying Cause (Disease or Injury that initiated events cause.					uence of):										
ρΩ,	be executed sician and burial-transit		resulting in death) L	ast	c	Due to (or as	a consequ	uence of):										
	cate be ohysici the bu	dical			d													
	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ M6 9 □ Unknown   23c. If yes, outcome pf pregnancy   1 □ Live birth 2 □ Fetal death   3 □ Ectopic pregnancy   23d.								23d. Date Mon		y Day	Year				
Τ.	requires that the reen signed by th hould be detache	by Pr	Part II. Other signif			-		_		cause give	en in Part	i.	23e. Did	tobacco	use contri	bute to the		
ecords,	require een siç hould t	ted	003	tructive	e di	n wau	1 d	veare	-				1 🗆	Yes 2	□ No :	3 🗌 Proba	biy 4	☑ Unknown
L Lec	The la ate has page 2	Completed											24a. Wa: auto peri 1∐ Yes	opsy formed?	pr	/ere autop rior to com eath? □Yes	pletion o	gs available of cause of
VII	Physician: r this certific ral director,	Be	25. Was case reference examiner?	_	Hospita	al:		ED/0 : "		Othe	or.		(Check only					
Ö	Ş iş p	n: To	27. Manner of Deat	h		a. Date of inju	ıry	28b. Time o		28c. injun Work	4 ⊔ N	- 1	me 5 Res 28d. Describe				)	
UNISION	tendin eath. tor: Aft the fun	catio	1 → Natural 5 → Pending (Month, Day) 2 → Accident investigation 3 → Suicide 6 → Could not be					Year)										
5	ial or At s after d al Direct ed in by	Certification:	4 Homicide	determ		e. Place of inj building, et	ury - At ho c. <i>(Specif</i> )	ome, farm, str y)	eet, factor	y, office			28f. Location City or To	(Street ar own, State	nd Numbe e)	r or Rural	Route N	umber,
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical C	29a. Certifier (Check only one)	1⊟ Certifyin 2□ Medicai	Examiner: C	: To the best On the basis o nd manner st	f examina	wledge, deat tion and/or in	h occurred vestigation	at the tin	ne, date a	and place,	and due to the	e cause(s e, date an	and mar	nner as sta nd due to	ited. the caus	e(s)
	To the Comp	M	29b. Signature and	title of certifier		MD				c. License	e number	41			ite signed			
2	(12)		30. Name and addr			ed cause of d	leath (Item	23a) (Type,	Print)	EET,	EAS	STON	, MD	21	1601			

State Registrar

31. Date filed (Month, Day, Year)

NOV 1 3 2007

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2007 10:10AM NOV Nagah Tawfik Gad /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Lothian 111 Patuxent Mobil Estates If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 X F Egypt AUG 6, 1964 43 Director 223-95-4073 Usual Residence of Decedent Department of Health and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medieral Francisco. 10a State 10h County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 No Director Maryland | Anne Arundel Lothian 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 111 Patuxent Mobile Estates 20711 Egypt Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Optical Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Tawfik Gad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20711 Jerome Armfield/Husband 111 Patuxent Mobile Estates, Lothian, MD 20b. Place of Disposition (Name of cemetery, crematory or other plane)
Fairfax Memorial
Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 11/12/2007 Fairfax, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility
Fairfax Memorial Funeral Home M00956 9902 Braddock Rd., Fairfax, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 Years Breast Cancer, Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit certificate be executed Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day ρ in the past 12 months? 1 ☐ Yes 2 🕱 No Year 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed | 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2【 No 24a. Was an autopsy page certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient ဥ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760. P.0. Division or Vital Records, To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

Baltimore, Maryland 21215-0036

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

PHYSICIAN

and manner stated.

29c. License number D53590

29d. Date signed (Month, Day, Year) NOV 9, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8200 Professional Place Ste. 104 Landover, MD 20785 Sydney Dy, MD 31. Date filed (Month, Day, Year) NOV 13 2007

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copi	es Are Legible.
State of Maryland / Department of Health and Mental	Hygiene
Certificate of Death	Beg. No. ○ ○ □

			State of Marylan				lental Hy	giene	
		-	1 - State Registrar	Cert	tificate of L	Death		Reg. No.	7 37999
	Physicia	an	1. Decedent's Name (First, Middle Last)				2. Date of De Month	Day Yea	
	/Medic	al	4a. Facility Name (If not institution, give street and number)	rue		Location of Death	lovem	4c. County of De	
	Examin	er	Charter River Hospital Co	ster	Che	. 1 1.	an.	Ker	t
P 340	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. 062-03-2766 X M 2 F 89		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	Director		062-03-2766	Yrs.			FEB. 1	3, 1918	NY
3	yland iow at			fy, Town or Loc	ation				10d. Inside City Limits
	e Mar a-f sh tified	ctor	MD KENT	CHESTER	RTOWN				1 XYes 2 No
	or 28 be no	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	sath v	Funeral	101 H MORGNEC RD.  11. Marital Status  12. Was Decedent Ever in U.	S 13. W	/as Decedent of H	21620 ispanic Origin? (Sr	ecify Yes or No	USA 14. Race - A	merican Indian,
	ritter d	Fun	Armed Forces?  1 □ Never Married 2 ★ Married   Yes 2 □ No ₩₩1   Yes 3 □ No ₩ W1	I I		ispanic Origin? (Span, Mexican, Puerto	Rićan, etc.)		
3	ours a	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		□Yes 2 <b>X</b> No	Specify:			WHITE
5	"natu	lete	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup aind of work done of ONOT use retired	during most of work	ing	16b. Kind of Busine	ss/Industry
7	withir iene.  than the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		LESMAN	,		LEGAL DO	CUMENTS
2	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle	, Maiden Surname)	
Z Z	ould b Ments arked atic e	To	EDGAR M. GRUEN			ETHEL B			
	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type. Print)  ROBERT B. GRUEN, JR./ SON			and Number or Ru EATH, MA		er, City or Town, Stat	e, Zip Code)
ע	s 1 and 2 should be flied within 72 hours after death with the Marylar f Heathth and Mental Hygiene. The fleathth and Mental Hygiene fleen 271 is marked other than "natural", or Items 23a or 28a-f show them 21 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	}	20a Method of Disposition 20b. F	L Place of Dispos	ition (Name of	ŧ	Date	20c. Location - City	or Town, State
	Pages nent of I int: If Ite		1 Bunal 2 Eremation 3 Removal from State		atory or other plac <b>CREMAT</b> ]	1	/07	STEVENSVI	LLE, MD
<u> </u>	permit. Pages 1 au Department of Hes Important: If Item any Injury or othe once.		21. Signature of Funeral Service Licensee	1				ELFENBEIN	
۵	ಕ್ರಾ ಕರ್ಮ		Bick of Helfenbein	1				, MD 21620	
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not ente	r the mode of dyin	ig, such as cardiac	or respiratory a	irrest,	Approximate Interval Between Onset and Death
	Physician /Medical	6	disease or condition resulting in death)  Due to (or as a consequence)	y Hear	fallen				
	Examiner		Myseon	dist	Culous.	tim			
ļ.	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):	0				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conseq						
0000	ate be executed hysician and the burial-transit	al E	Due to (of as a conseq	jacrioc orj.					
000	ificate g phys	edical	d					1	
5	th cert ending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		23d. Date of Month	· ·
	e deal	sicia	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown    In the past 12 months?   Unknown   Unknown		Other (specify)	<u></u>		Month	Day Year
Ţ.	that the ed by detach		Part II. Other significant conditions contributing to death but not res	sulting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco use contribut	e to the cause of death?
S,	uires signe	d by	Merronia				10	Yes 2EIN 3	Probably 4 Unknown
spiosa	aw rec s beel 2 shou	Completed					24a. Was	an 24b. Were	e autopsy findings available to completion of cause of
Ĕ	The I	mo					perf 1□ Yes	ormed? deat	h?
N I G	cian: sertific ector,	Be	25. Was case referred to medical examiner?		Oth	26. Place of Dea			
5	Phys r this ral dir	٠ <u>۲</u>	1 Yes 2 No 1 Inpatient 2 27. Manny of Death 28a. Date of Injury	ER/Outpatient 28b. Time of	1 3 DOA Oth 28c. Injur Wor	T I I I I I I I I I I I I I I I I I I I		idence 6 Other (5	Specify)
5	nding th. :: Afte e fune	Certification:	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		ḱ? Yes 2∐No			
<u>S</u>	r Atte	tifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Special Could not be building, etc. (Special Could not be building, etc. (Special Could not be building, etc.)	ome, farm, stre	et, factory, office		28f. Location (	(Street and Number o	r Rural Route Number,
ב	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as					mo data and -la	and due to the	course(s) and mar-	ar as stated
	Hosp 24 hol Fune etely f	edical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)						
	To the within To the compl	Me	29b. Signature and title of certifie		29c. Licens	se number		29d. Date signed (M	Ionth, Day, Year)
1			>// Unlew to		T 0.	066030	1	11/8/0	7
-	0		(Check only one)  2 Medical Examiner: On the basis of examiners and manner stated.  29b. Signature and title of certifier  30 Name and address of person who completed cause of death (Iter  31. Date filled (Month, Day, Year)  NOV 1 3 2007	m 23a) (Type, F	(2nt) 1. RD	5755	Chris	DON TOWN	1 MD
	Sta	ate 1	31. Date filed (Month, Day, Year) 32. Fi gistrar's Sign	ature	land.	, ,	.,,	, , ,	1
	Registr		NOV 1 3 2007	100	DOME!				

State Registrar